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

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FOSTER CARE

Agencies Face Challenges Securing Stable Homes for Children of Substance Abusers

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GAO

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Health, Education, and
Human Services Division

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September 30, 1998

The Honorable William V. Roth, Jr.
Chairman, Committee on Finance
United States Senate

Dear Mr. Roth:

Our nation's foster care population has nearly doubled since the mid-1980s, leading to dramatic increases in federal foster care expenditures. Today, about half a million children are in foster care,[1] and many of them have been in the system for years. The mid-1980s also marked the onset of the crack-cocaine epidemic. More recently, the use of other hard drugs such as methamphetamines and heroin has been on the rise in some parts of the country. Research suggests that the escalating use of hard drugs has contributed to the growth in the foster care population. While we know that children often enter foster care because of neglect associated with parental substance abuse, little information exists on the effect parental substance abuse has on how and when children leave the system. Because of concerns about children languishing in foster care, the Congress recently enacted legislation that places a greater emphasis on adoptions for children who cannot be safely returned to their parents in a timely manner.[2]

Because of your concern that children whose parents abuse drugs or alcohol may remain in foster care for long periods of time before they are placed in a safe, permanent home, you asked us to provide information on (1) the extent and characteristics of parental substance abuse among foster care cases, (2) the difficulties foster agencies face in making timely permanency decisions for foster children with substance abusing parents, and (3) initiatives that address reunifying families or achieving other permanency outcomes in a timely manner for foster children whose parents are substance abusers.

Data on the extent and characteristics of parental substance abuse among foster care cases are limited. To obtain such information, we developed and administered a questionnaire that was completed by caseworkers for random samples of foster care cases in California and Illinois that were in

[1]The term "foster care" in this report refers to all types of out-of-home foster care for children to protect them from abuse and neglect at home. These placements include family homes (both relative and nonrelative), private for-profit or nonprofit child care facilities, or public child care institutions. In Illinois, all of these placements together are referred to as "substitute care."

[2]The Adoption and Safe Families Act of 1997 (P.L. 105-89) was enacted on November 19, 1997.

the system as of June 1, 1997, and had been in continuously since at least March 1, 1997. Together, these two states account for about one-quarter of the nation's foster care population. To provide information about the difficulties foster care agencies might have making timely permanency decisions for foster care cases involving parental substance abuse, we conducted case studies of foster care programs in Los Angeles County, California; Cook County, Illinois; and Orleans Parish, Louisiana. We focused on these three urban counties because they have large foster care caseloads and large populations of substance abusers. We selected these particular counties because they provide a geographic mix and have foster care laws or initiatives that address parental substance abuse and permanency decisionmaking. In each of our case study locations, we interviewed foster care program and policy officials, caseworkers, dependency court judges and attorneys, and drug treatment providers. At each location, we also reviewed the files for a small number of foster care cases with different outcomes, each involving parental substance abuse. We conducted our fieldwork in compliance with generally accepted government auditing standards between April 1997 and June 1998. Our scope and methodology are discussed further in appendix I. Appendix II contains the questionnaire that we used to collect data on the extent and characteristics of parental substance abuse among foster care cases, and appendix III contains the survey results.

Results in Brief

On the basis of our survey, we estimate that about two-thirds of all foster children in both California and Illinois, or about 84,600 children combined, had at least one parent who abused drugs or alcohol, and most had been doing so for at least 5 years. Most of these parents abused one or more hard drugs such as cocaine, methamphetamines, and heroin. Substance abusers often abandon or neglect their children because their primary focus is obtaining and using drugs or alcohol. They also place their children's safety and well-being at risk when they buy drugs or engage in other criminal activity to support their drug habit. Recovery from drug and alcohol addiction is generally a difficult and lifelong process that may involve periods of relapse.

Parental substance abuse makes it more difficult to make timely decisions that protect foster children and provide them with stable homes. Foster care agencies face difficulties in helping parents enter drug or alcohol treatment programs. In addition, foster care agencies and treatment providers may not always be adequately linked, and as a consequence, close monitoring of parents' progress in treatment does not always occur.

Finally, foster care agencies also face several challenges when trying to quickly achieve adoption or guardianship in these cases after family reunification efforts have failed.

To accommodate children's need for timely permanency decisions, some locations have launched highly collaborative initiatives, involving drug treatment providers and sometimes the courts and other organizations, to help parents obtain treatment for their addictions and to closely monitor their progress in treatment. In addition to maximizing the prospects for reunification, these initiatives may produce the detailed information about parents' progress in treatment that judges need to make timely permanency decisions. Some locations are undertaking other efforts to better enable foster care agencies to quickly achieve other permanency outcomes for children who cannot be safely returned to their parents in a timely manner. While not designed specifically for foster care cases involving parental substance abuse, such efforts may be useful in these cases. For example, concurrent planning is being used to reduce the time it takes to achieve permanency by simultaneously working to reunify the family and planning for some other permanency outcome should family reunification efforts fail. Some locations are also implementing programs to encourage relatives of children in foster care to adopt or become the legal guardians of these children.

Background

Foster care laws and regulations have historically emphasized the importance of both reunifying families and achieving permanency for children in a timely manner. Permanency outcomes from foster care include family reunification, adoption, and legal guardianship.[3] The Congress recently enacted legislation that places a greater emphasis on adoption when foster children cannot be safely returned to their parents in a timely manner. Failing to secure a safe, permanent home for foster children before they reach age 18—sometimes referred to as aging out of the foster care system—can have damaging consequences for their emotional stability and future self-sufficiency.[4]

Although federal law requires states to make "reasonable efforts" to reunify foster children with their parents,[5] neither federal laws nor

[3]A legal guardian is someone who assumes legal responsibility for the care of a child. Parental rights do not have to be terminated in order to establish a legal guardianship.

[4]Services to help these young adults become self-sufficient are sometimes provided until they are 21 years of age.

[5]The Adoption Assistance and Child Welfare Act of 1980 (P.L. 96-272).

regulations clearly define "reasonable efforts."[6] At a minimum, the law does require states to develop a case plan with a permanency goal. When family reunification is the goal, the case plan must describe the services—such as drug or alcohol treatment, counseling, or parenting classes—that will be provided to help parents rectify the problems or conditions that led to their children entering foster care. In order to evaluate the progress that parents have made in complying with their case plan requirements, states are required to hold court or administrative reviews every 6 months. They also must hold permanency planning hearings at which the judge must determine whether to continue family reunification efforts or begin to pursue some other permanency goal, such as adoption or guardianship. In determining if and when to end efforts to reunify the family, foster care agencies and the courts must balance the goals of reunifying children with their parents and meeting children's need for timely permanency.

The Adoption and Safe Families Act of 1997 (P.L. 105-89) emphasizes that a child's health and safety are of paramount concern by specifying situations in which states do not have to make reasonable efforts to reunify the family before parental rights can be terminated.[7] This law also stresses the importance of securing safe, permanent homes for children in a timely manner by (1) requiring states to file a petition to terminate parental rights (TPR) if the child has been in foster care for at least 15 of the most recent 22 months,[8] (2) shortening from 18 to 12 months the time period within which a permanency planning hearing must be held,[9] and (3) providing incentive payments to states for increasing the number of foster children who are adopted. This law also authorizes funds for time-limited family reunification efforts.[10]

[6]The lack of a specific definition of "reasonable efforts" has been a source of controversy, and allegations that the state has failed to meet the reasonable efforts requirement have been used as grounds for contesting permanency decisions.

[7]These include cases in which a parent has committed murder or voluntary manslaughter or in which parental rights for another child have already been involuntarily terminated. This provision may also apply, at the state's discretion, in cases of abandonment, torture, chronic abuse, or sexual abuse.

[8]Exemptions from this requirement are allowed if (1) the child is placed with a relative; (2) reasonable efforts to reunite the family have not been made; or (3) there is a compelling reason, documented in the case file, indicating why it would not be in the best interest of the child to terminate parental rights at that time.

[9]While a permanency decision is not required at the time of the initial permanency planning hearing, states are expected to submit a permanency plan for the child at this hearing, for the judge's approval. The plan should reflect whether the permanency goal for this child is family reunification or some other permanency outcome, such as adoption or guardianship.

[10]These monies are available only during the 15-month period that begins on the date the child is considered to have entered foster care.

Currently, data on foster care outcomes—including family reunification rates—and length of stay in foster care are limited.[11] A longitudinal study of foster care outcomes in California found that, while 44 percent of children who entered foster care in 1990 as infants were reunified with their families within 4 years, 37 percent were still in care after 4 years.[12] This study also showed that foster care outcomes vary by placement type, age at entry, and ethnicity. Data on how parental substance abuse may affect the length of time children spend in foster care and their outcomes are particularly limited. However, Illinois reported that the percentage of foster children who were reunified with their families dropped between 1990 and 1995, which foster care agency officials attribute to the "epidemic level of parental drug abuse."[13] Parental substance abuse may also result in children re-entering foster care. The California study cited above found that among those who were reunified with their families, 28 percent re-entered foster care within 3 years. This study found that parental substance abuse was particularly common among cases in which children had re-entered foster care.

Research suggests that children who spend long periods of time in foster care, or age out of the system before a permanency outcome has been achieved, may have emotional, behavioral, or educational problems that can adversely affect their future well-being and self-sufficiency. A study of the title IV-E foster care independent living program, which assists children in their transition from foster care to self-sufficiency, found that about 2-1/2 to 4 years after aging out of the system, 46 percent of foster children had not completed high school; 38 percent had not held a job for longer than 1 year; 25 percent had been homeless for at least 1 night; and 60 percent of those who were female had given birth to a child. Furthermore, 40 percent had been on public assistance, incarcerated, or a cost to the community in some other way.[14]

[11]The Department of Health and Human Services' (HHS) Adoption and Foster Care Analysis and Reporting System (AFCARS), which is in the early stages of implementation, requires states to report detailed, case-specific information. In the future, information on how parental substance abuse affects the length of time children remain in foster care and case outcomes may be available through this database. HHS will be using AFCARS data to track foster care agencies' progress in meeting HHS program goals under the Government Performance and Results Act (GPRA).

[12]Barbara Needell, Ph.D., "Permanence for Children Entering Foster Care as Infants." Family Welfare Research Group, Child Welfare Research Center, School of Social Welfare, University of California at Berkeley.

[13]Child Protective and Child Welfare Services Fact Book, FY 1995, Illinois Department of Children and Family Services, December 1996.

[14]A National Evaluation of Title IV-E Foster Care Independent Living Program for Youth: Phase II Final Report, Vols. I and II (Rockville, Md.: Westat, Inc., 1991).

The Department of Health and Human Services (HHS) is responsible for the management and oversight of federal programs providing services to foster children. HHS issues federal foster care regulations, monitors states' compliance with them, and administers federal funding. Federal foster care funds are authorized under title IV-E of the Social Security Act of 1935. Title IV-E is an uncapped entitlement program that reimburses states for a portion of the maintenance cost for foster children whose parents meet federal eligibility criteria related to their income level. Federal expenditures for the administration and maintenance of children eligible for title IV-E funding increased from about $546 million in 1985 to an estimated $3.3 billion in 1997. States and counties must bear the full cost for maintaining foster children who are not eligible for title IV-E funding.[15]

Children are exiting foster care at a slower rate than they are entering. As a result, the foster care population nationwide has nearly doubled since the mid-1980s, increasing from about 276,000 in 1985 to about 500,000 in 1997. Following the advent of crack-cocaine in the mid-1980s, cocaine use increased dramatically and reached alarming proportions by the end of the 1980s. Research indicates that the "crack epidemic" may have contributed to the increase in foster care caseloads. We reported that, in 1991, nearly two-thirds of foster children 36 months of age or younger in Los Angeles County, New York City, and Philadelphia County combined were known to have been prenatally exposed to drugs or alcohol. Most of them were exposed to cocaine.[16] Although research indicates that the number of new crack-cocaine users is declining, chronic use among parents of foster children is still common.

While crack-cocaine use is declining, the use of other hard drugs is on the rise. Methamphetamine use has been growing, particularly in the West and Southwest, and there is a resurgence of heroin use throughout much of the country. Heroin's growing popularity may stem from its sharply increased availability; decreased cost; and higher purity level, in a form that does not need to be injected. Both crystallized methamphetamines and crack-cocaine are inexpensive, smokable drugs that produce immediate and intense highs and increased alertness.

In March 1998, we reported that major studies have shown that drug treatment is beneficial, although concerns about the validity of

[15]The proportion of foster children who are eligible for federal IV-E funding has increased from about 40 percent in 1985 to about 50 percent in 1997.

[16]Foster Care: Parental Drug Abuse Has Alarming Impact on Young Children (GAO/HEHS-94-89, Apr. 4, 1994).

self-reported data suggest that the degree of success may be overstated.[17] Nonetheless, substantial numbers of clients do report reductions in drug use and criminal activity following treatment. Research also indicates that those who remain in treatment for longer periods generally have better treatment outcomes. Methadone maintenance has been shown to be the most effective approach for treating heroin abuse. Research on the best treatment approach or setting for other groups of drug abusers, however, is less definitive. To date, there is no effective pharmacological treatment for cocaine abuse, but studies have shown that several cognitive-behavioral treatment approaches show promise for treating cocaine addiction. Little is known about the effectiveness of treating methamphetamine addiction.

Parental Substance Abuse Is Prevalent Among Foster Care Cases and Makes Reunifying Families Extremely Difficult

According to our survey, most children in foster care in California and Illinois had at least one parent with a serious and long-standing substance abuse problem that makes recovery extremely difficult. Most of these parents had been abusing drugs or alcohol for 5 years or more. About two-thirds of these parents had used one or more hard drugs such as cocaine, heroin, or methamphetamines. These hard drugs are highly addictive and debilitating and can greatly diminish the ability to parent. These substance-abusing parents often neglect their children because their primary focus is obtaining and using drugs. In addition, substance abusers often engage in criminal activity that can threaten the safety and well-being of their children. Recovery from drug and alcohol addiction depends on many factors, such as the substance abuser's readiness for recovery, and relapse is common.

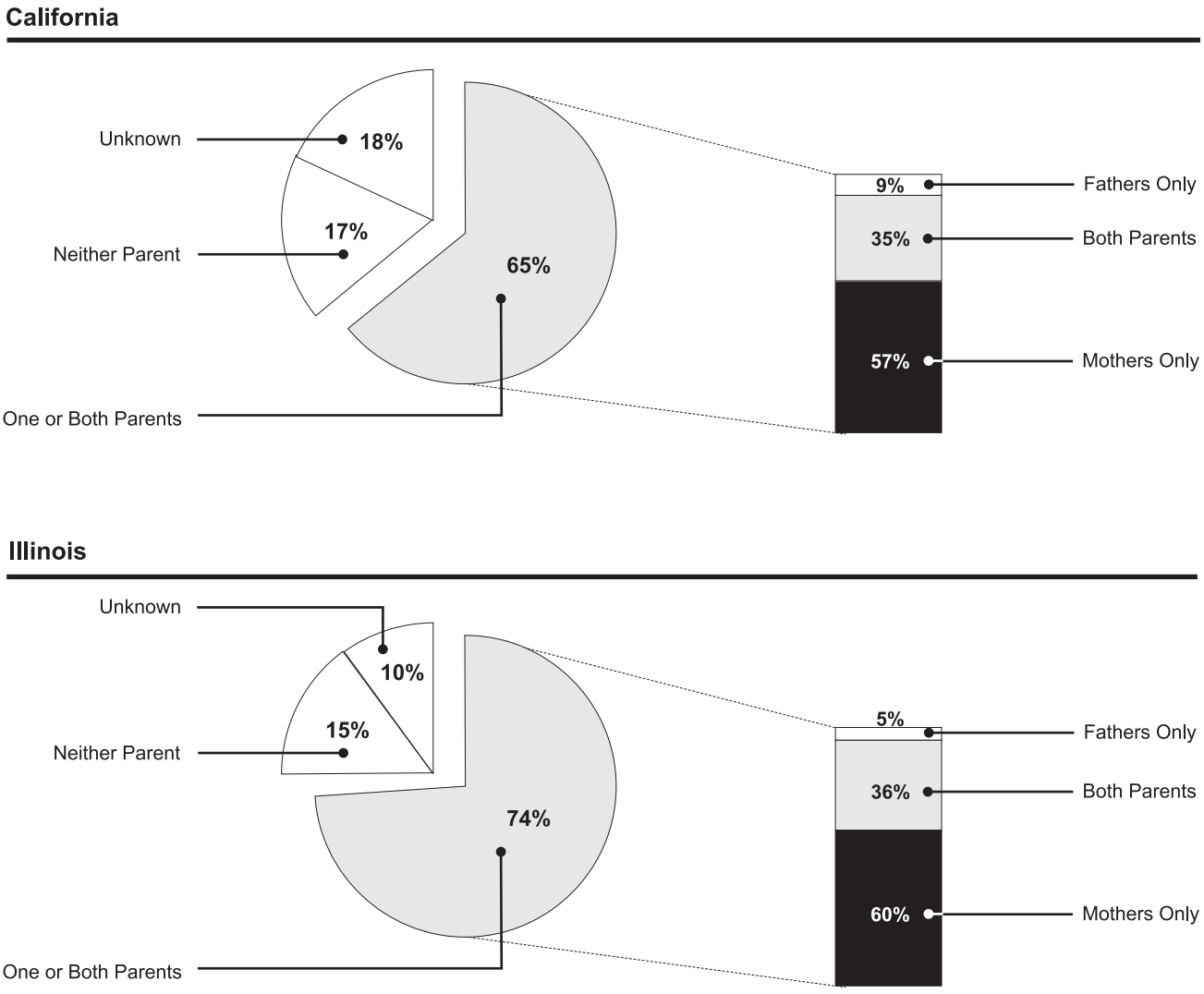
Parental Substance Abuse Is Involved in Most Foster Care Cases

On the basis of the results of our survey, we estimate that about 65 percent of the foster children in California and 74 percent in Illinois, or about 84,600 children combined, had at least one parent who was required to undergo drug or alcohol treatment as part of the case plan for family reunification. (See fig. 1.) In about 40 percent of these cases in each state the father was required to undergo drug or alcohol treatment, while the mother was required to undergo treatment in over 90 percent of these cases in each state. In about one-third of the cases involving parental substance abuse in each state, either the father was deceased or his whereabouts were unknown. As a result, the mother was usually the focus of the foster care agency's family reunification efforts. Caseworkers in our

[17]Drug Abuse: Research Shows Treatment Is Effective, but Benefits May Be Overstated (GAO/HEHS-98-72, Mar. 27, 1998).

case study locations explained that fathers whose whereabouts are unknown may not even be aware they have children in the foster care system; and even if they are aware, they may never have been involved in the care of their children.

Figure 1: Foster Care Cases in Which a Parent Was Required to Undergo Treatment for Drug or Alcohol Abuse



Notes: Percentages may not total 100 because of rounding. About 30 percent of the fathers and less than 4 percent of the mothers in each state were deceased or their whereabouts were unknown. See also tables III.1 and III.2 in app. III.

Source: GAO survey of open foster care cases in California and Illinois.

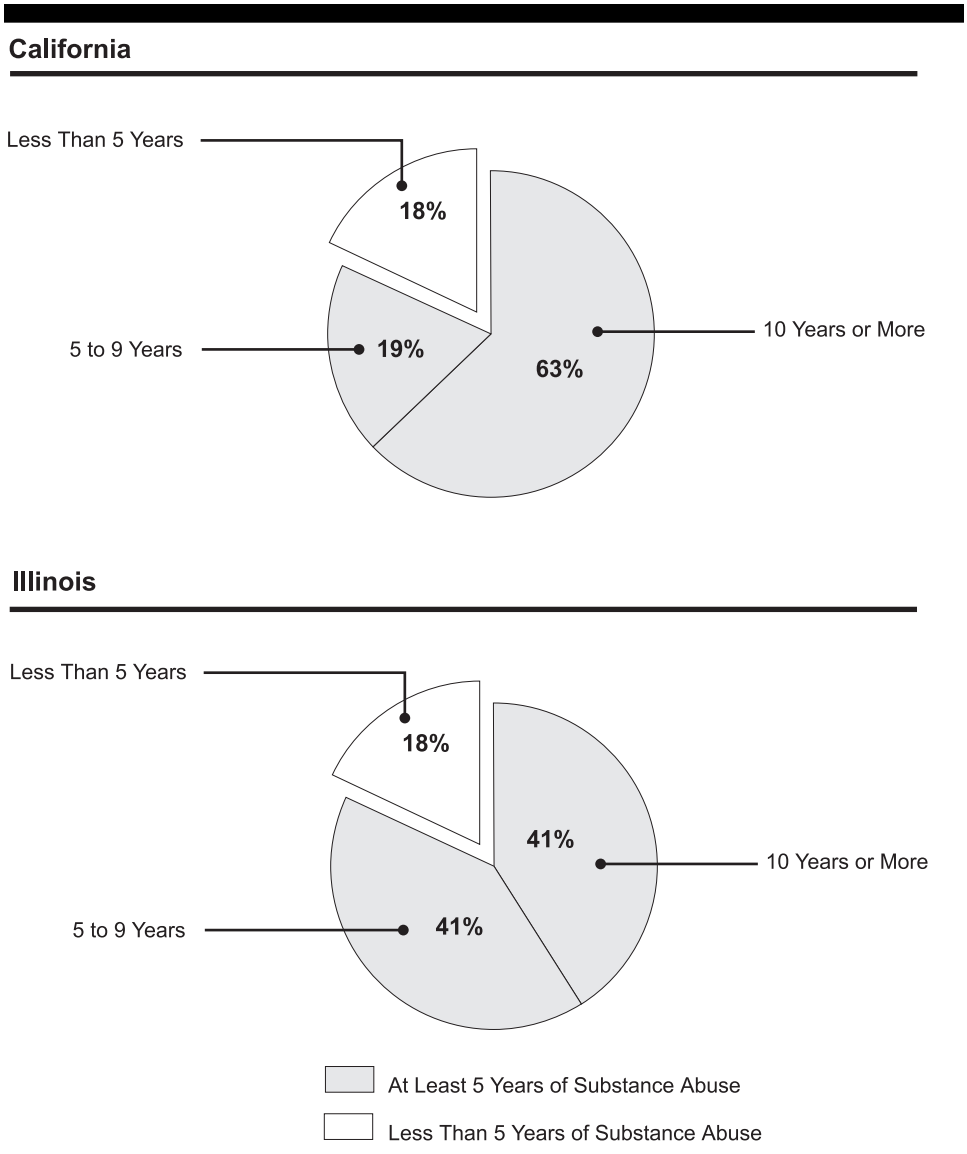
Most Substance Abusing Parents Have Serious and Longstanding Drug or Alcohol Abuse Problems

In both California and Illinois, at least two-thirds of the substance-abusing parents of foster children in our survey used cocaine, methamphetamines, or heroin—hard drugs that are highly addictive and debilitating. In each state, about 50 percent of the mothers who abused drugs or alcohol used more than one substance. Alcohol was often used in combination with one or more of the hard drugs mentioned above, although alcohol abuse alone was much less common in both states. Less than 10 percent of the substance-abusing mothers in each state used only alcohol. In some instances, substance-abusing parents in each state were using marijuana.[18]

According to our survey, substance-abusing parents of foster children not only abused hard drugs but most had been doing so for a long time. In each state, over 80 percent of the substance-abusing mothers of foster children in our survey had been abusing drugs or alcohol for at least 5 years, many of them for more than 10 years. (See fig. 2 .)

[18]Although the use of hard drugs was more prevalent in the population we surveyed, according to HHS officials, both marijuana and alcohol also have significant consequences for parents and their children.

Figure 2: Length of Time Mothers Have Abused Drugs or Alcohol



Notes: Data on the length of time that mothers abused drugs or alcohol were missing in about one-third of the cases in each state. Because data were more often missing for fathers, this analysis was limited to mothers. See also table III.12 in app. III.

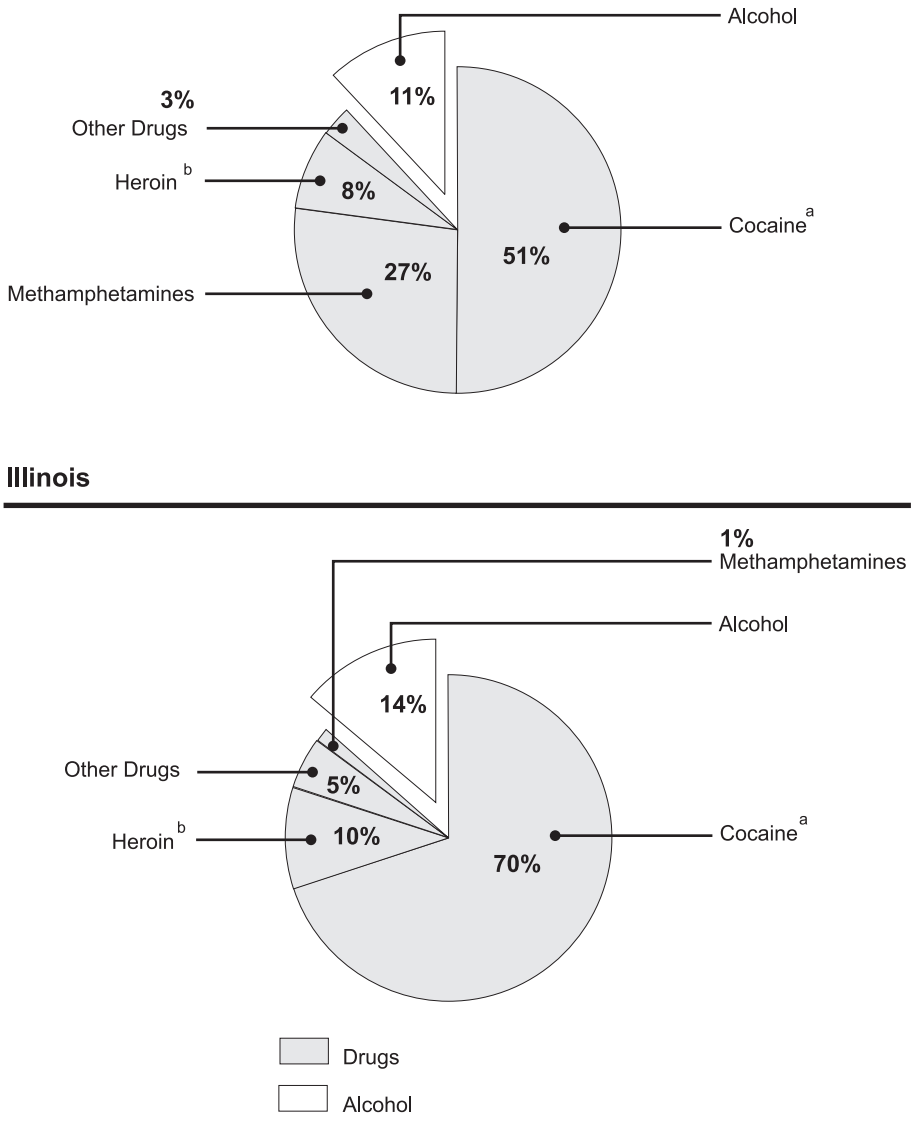
Source: GAO survey of open foster care cases in California and Illinois.

Substance Abuse Greatly Diminishes the Ability to Parent

Cocaine, methamphetamines, and heroin—the hard drugs used by most substance-abusing parents of foster children in our survey—are highly addictive and can greatly diminish the ability to parent. Cocaine was most often the drug of choice among substance-abusing mothers of foster children in each state.[19] We identified some variation in other drugs of choice, by state. Methamphetamines were often the drug of choice among the substance-abusing mothers of foster children in California but were seldom used by mothers in Illinois. Heroin was the drug of choice for about 10 percent of substance-abusing mothers in each state. (See fig. 3.) Foster care agency officials and drug treatment providers in all three of our case study locations believed that heroin use was on the rise among parents of foster children within their jurisdictions.

[19]Among cases in which cocaine was the drug of choice, when the type of cocaine was specified, it was usually crack-cocaine.

Figure 3: Mother's Drug of Choice Around the Time This Foster Care Episode Began



Notes: Percentages may not total 100 because of rounding. The drug of choice for mothers was missing in about 42 percent of the cases in California and 25 percent of the cases in Illinois. Because data were more often missing for fathers, this analysis was limited to mothers. See also table III.11 in app. III.

[a]Represents the total percentage for all forms of cocaine.

[b]Includes a small percentage of other opiates.

Source: GAO survey of open foster care cases in California and Illinois.

Parents who use hard drugs may be unable to meet even the basic needs of their children. Their use of hard drugs can lead to erratic behavior that places the safety and well-being of their children at risk. For example, the immediate effects of both crack-cocaine and crystallized methamphetamines include hyperstimulation and an amplified sense of euphoria. Crack-cocaine users may also experience feelings of depression, restlessness, irritability, and anxiety, and prolonged use can lead to paranoid behavior. Because the high produced by crystallized methamphetamines can last between 8 and 24 hours, when the effects wear off, users go into a deep sleep that can last for several days. Users sometimes are susceptible to psychological problems including depression, paranoia, and hallucinations. In extreme cases, methamphetamine use may also lead to suicidal tendencies and violent outbursts. Heroin and other opiates tend to relax the user, but users may also experience restlessness, nausea, and vomiting. Heroin causes users to go back and forth from feeling alert to feeling drowsy. With very large doses of heroin, users can become unconscious and, in some cases, may die.

A foster care case we reviewed illustrates the extreme effect drug abuse can have on parents' ability to care for their children. A mother with a long history of abusing crack-cocaine and other hard drugs reportedly pointed a gun at her two daughters and threatened to kill them and herself. The child this case pertains to had marks on her body from physical abuse she had suffered at the hands of her mother. She was removed from her mother's custody and never reunified with her. This child was quoted in the case file as saying that "cocaine took over her [mother's] mind—she used to be a good mother." A more detailed description of this case, and the other cases we reviewed, is contained in appendix IV.

Most children with substance-abusing parents enter foster care because their parents fail to meet their basic physical and emotional needs. In both California and Illinois, neglect was the primary reason for entry into foster care in over 80 percent of the foster care cases in our survey involving parental substance abuse. Physical and sexual abuse were far less often the reason for entry, together accounting for only about 14 percent of the cases involving parental substance abuse in California and 7 percent in Illinois. Because of the nature of addiction, obtaining and using drugs or

alcohol are the most important focus in the lives of substance abusers. As a consequence, the safety and well-being of their children is often secondary to their addiction. Research suggests that substance-abusing parents of children in foster care do not always form healthy emotional attachments with their children and may have limited parenting skills.[20] These parents may abandon their children at birth or sometime later in their lives, be periodically absent from the home, or leave their children in unsafe environments. According to our survey, in both California and Illinois, over 80 percent of the foster children with substance-abusing parents had at least one other sibling who was also in foster care as of September 15, 1997.

We found many examples of neglect associated with drug abuse in the cases we reviewed. In one case, the mother's crack-cocaine use caused her to leave her children for the night with unrelated adults after telling them she would return in only a few minutes. In another case, the mother left her children with her brother, who also abused drugs, while she went out to sell diapers, cigarettes, bus tokens, and food stamps in order to buy cocaine. In a third case, after the family was evicted from its apartment, the mother left her three children with a friend. They had not seen their mother for about 2 weeks when the friend contacted the foster care agency.

Finally, when parents abuse illicit drugs, they also expose their children to crime. In addition to purchasing illicit drugs, substance abusers sometimes engage in criminal activity such as theft, prostitution, and drug sales to support their habits. In both California and Illinois, over one-third of the foster care cases in our survey that involved parental substance abuse also involved some type of criminal activity by at least one of the parents around the time of the child's foster care episode. Children whose parents abuse illicit drugs also sometimes witness, or are the victims of, violence. For example, in a case we reviewed, the mother, who was pregnant and abusing cocaine, was attacked by drug dealers for allegedly stealing drugs. This attack exposed her unborn child to considerable physical harm, and the infant had to be delivered by emergency cesarean section as a result of the attack.

[20]Judy Howard, "Barriers to Successful Intervention," When Drug Addicts Have Children: Reorienting Child Welfare's Response, ed. Douglas J. Besharov (Washington, D.C.: Child Welfare League of America & American Enterprise Institute, 1994). In this study, observations of mothers who used drugs heavily revealed that they were significantly less sensitive, responsive, and accessible to their infants than mothers who were not substance abusers; and their infants showed insecure attachments toward them.

Recovery From Drug and Alcohol Addiction Depends on Many Factors and Relapse Is Common

According to research on drug and alcohol treatment, the potential for recovery depends on many factors, including the types of substances used, the length of time they are used, readiness for recovery, access to appropriate treatment, and the length of time in treatment. In addition, other problems, such as mental illness, medical conditions, and a criminal lifestyle can greatly complicate the recovery process. Treatment providers we spoke with said that some drug addicts or alcoholics may not be ready to recover until they "hit bottom" or recognize that they can no longer continue their drug or alcohol abusing lifestyle. According to HHS officials, placement of their children in foster care is often the "bottoming out" experience needed to get parents into treatment for their substance abuse problems. Some treatment providers believe that, regardless of whether or not a parent has hit bottom, effectively engaging the addict in treatment is key to recovery.

Many experts believe that a successful course of drug treatment involves a continuum of treatment approaches and services. Women with children often need intensive treatment because their fear of losing custody of their children often prevents them from seeking treatment on their own. As a consequence, by the time they come to the attention of the child welfare system their addiction is usually far advanced. In addition, according to HHS, informed sources generally believe that treatment for women must address issues unique to women, such as sexual abuse, domestic violence, child care, and health problems.

Recovery from drug and alcohol addiction is generally characterized, by drug treatment professionals, as a difficult and lifelong process that frequently involves periods of relapse. According to some treatment experts, relapse is a stage in the recovery process that indicates progress toward recovery when it is accompanied by increasing periods of abstinence from drugs or alcohol. Brief relapses may enable recovering addicts to understand what triggers their return to drugs and help them develop ways to prevent future relapses.

Among substance-abusing mothers in our survey whose children had been in foster care for at least 1 year, about 40 percent of these mothers in each state had entered treatment programs but failed to complete them, usually because of relapse. In some instances, mental illness, incarceration, or medical conditions were cited as the reasons these mothers had failed to complete treatment.

The following case we reviewed illustrates how difficult the recovery process is for parents who abuse drugs. This case involved one of six children. He and most of his siblings were known to have been prenatally exposed to cocaine. As a result of neglect related to his mother's crack-cocaine and alcohol abuse, he entered foster care shortly after birth. His mother also had a criminal record, having been convicted of felony theft and misdemeanor drug possession, and had been incarcerated for probation violations. The identity of the father was unknown. His mother successfully complied with most of the requirements in the case plan for reunification—including visitation, a parenting class, and family therapy. However, about 2 years after this child entered foster care, his mother was dropped from a drug treatment program for lack of attendance. About that time, the permanency goal was changed from family reunification to long-term foster care. Over the next few years, the mother entered treatment several additional times but failed to complete any of these programs. About 3 months prior to the birth of his youngest sibling, the mother entered a 12-month residential treatment program, which she successfully completed. Because of her success in treatment, the child who was the focus of this case was returned to his mother for several trial visits after spending about 7 years in foster care. However, the mother subsequently failed several drug tests, indicating she had relapsed. At the time we reviewed the case, this child was still in foster care after almost 8 years.

Although many parents, like the mother in this example, are unable to make sufficient progress toward recovery to regain custody of their children after many years, caseworkers and drug treatment providers told us that some parents, even those with long histories of substance abuse, do recover and are able to provide a safe home for their children. Another case we reviewed involved the third oldest of five children. He entered foster care when he was 6 years old after his mother gave birth to her youngest and third prenatally cocaine-exposed child. The mother had a 14-year history of substance abuse and had previously come to the attention of the child welfare agency in the mid-1980s for medical neglect of one of her older children. She was unemployed, and the father was incarcerated at the time the children were placed in foster care. Despite the complicated family situation, the mother successfully complied with all of the case plan requirements during this child's foster care episode. She spent about 1 month in a women's residential treatment program and another month in an outpatient program and participated in follow-up drug treatment support groups. She visited this child as prescribed in the case plan, attended parenting classes and counseling sessions, and

obtained subsidized housing. The child was returned to his mother on a trial basis about 16 months after he entered foster care. About 21 months after this child entered foster care, his mother was granted permanent custody, and this case was closed.

Foster Care Agencies Face Many Challenges in Achieving Timely Permanency When Parental Substance Abuse Is Involved

In cases involving parental substance abuse, foster care agencies face several challenges when attempting to secure permanent homes for foster children in a timely manner. Foster care agencies face difficulties in helping parents enter drug or alcohol treatment programs. Links between foster care agencies and treatment providers may not always be adequate; and as a consequence, close monitoring of parents' progress in treatment does not always occur. Finally, agencies also face several barriers to quickly achieving adoption or guardianship in these cases when family reunification efforts fail.

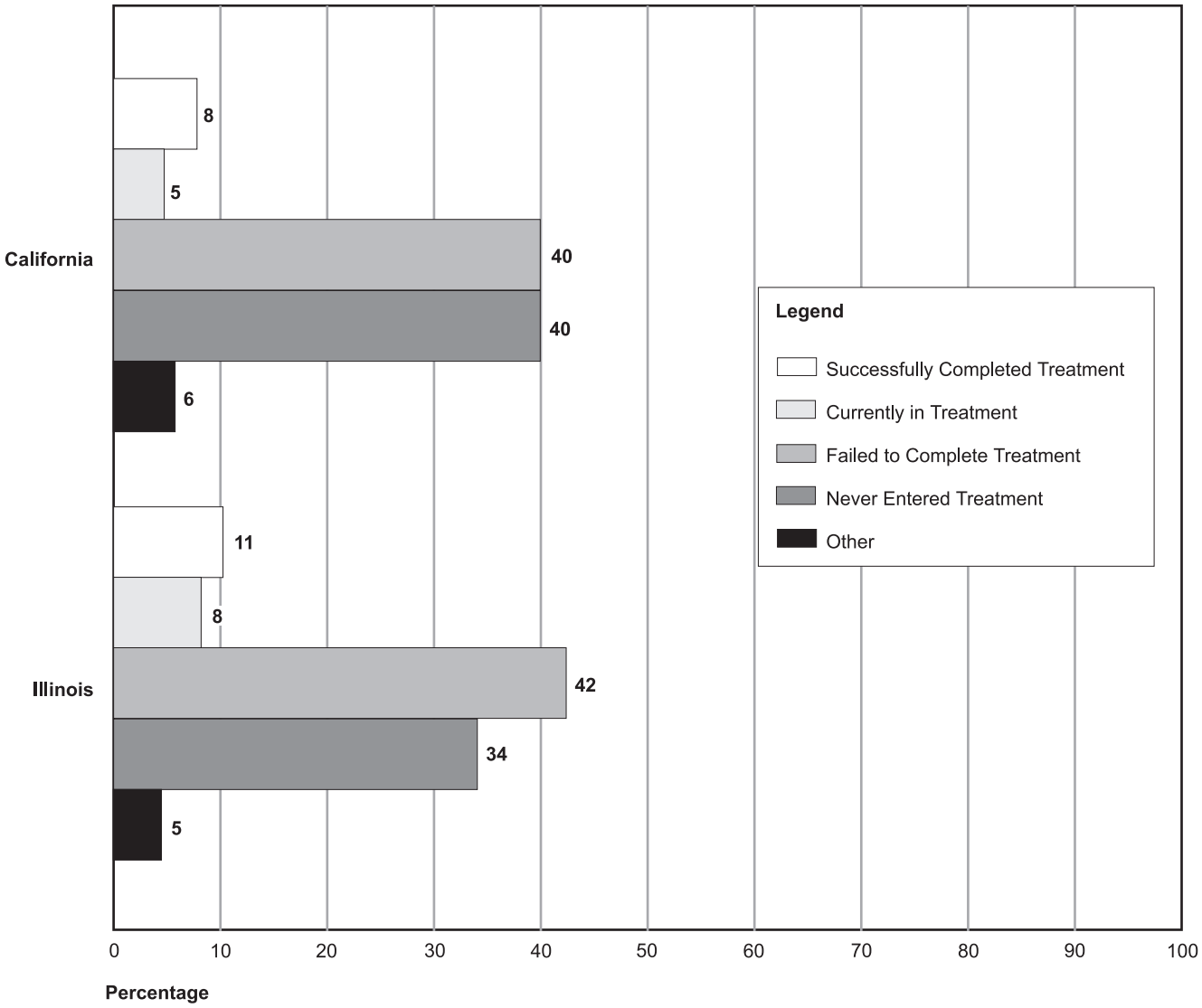
Foster Care Agencies Face Difficulties in Helping Parents Enter Drug or Alcohol Treatment Programs

Foster care agencies face the challenge of motivating parents to get into treatment. We learned at our case study locations that many parents who are substance abusers resist entering treatment. To parents, caseworkers represent the agency that took their children from them. As a result, many parents feel considerable anger toward caseworkers and anxiety about interacting with them, which can deter parents from entering treatment and delay their progress in fulfilling case plan requirements. Furthermore, according to drug and alcohol treatment providers and attorneys, some caseworkers lack sufficient understanding of the nature of drug and alcohol addiction, its role in individual foster care cases, and what they can do to help motivate parents to address their substance abuse problems.[21]

Among substance-abusing mothers in our survey whose children had been in foster care for at least 1 year, less than 20 percent in each state had either completed treatment or were currently in a treatment program. In California, about half of the remaining mothers had never entered treatment and about half had failed to complete it; in Illinois, a greater portion of the remaining mothers had failed to complete treatment than had never entered treatment. (See fig. 4.) Many factors influence whether an individual enters and completes treatment, including individual readiness for recovery.

[21]Research also indicates that some child welfare agency staff have little or no training related to drug and alcohol addictions. Child welfare workers themselves have identified their lack of knowledge regarding how to recognize substance abuse problems and treatment needs as a major barrier to effectively working with families in foster care cases that involve parental substance abuse.

Figure 4: Mothers With Children in Foster Care for at Least 1 Year, by Level of Progress in Treatment



Notes: Percentages may not total 100 because of rounding. Because fathers were often deceased or their whereabouts were unknown, this analysis was limited to mothers. See also table III.4 in app. III.

Source: GAO survey of open foster care cases in California and Illinois.

High caseloads and turnover among caseworkers make it even harder for caseworkers to help substance-abusing parents comply with their case plans.[22] Several caseworkers we spoke with said it is an ongoing challenge to meet the needs of these families, particularly because foster care caseworkers operate in a crisis-management mode.[23]

We learned at the locations we visited that foster care agencies may have limited familiarity with treatment resources in the community, which can delay parents' entry into drug or alcohol treatment programs. Experts believe that if entry into treatment is delayed, parents may lose the motivation to recover that the loss of custody of their children provided. Caseworkers said that they do not always know what treatment programs exist in the community, or whether there are slots available in these programs. As a result, parents are sometimes provided with a referral list that contains treatment programs that are no longer in operation or do not have immediate openings. A parent's entry into treatment and progress toward recovery can also be delayed while various treatment programs are contacted to find an opening or place the parent on a waiting list.[24]

Caseworkers and judges alike told us that a full array of alcohol and drug treatment settings is not available in some communities.[25] Many parents either are referred to or find it much easier to access less costly outpatient treatment programs because funding for residential treatment programs is limited. Although research has shown that outpatient treatment can be as

[22]High foster care caseloads have been documented nationally. The Child Welfare League of America (CWLA) reported that, in 1994, 25 states had a median caseload of 24 children to every caseworker. CWLA recommends caseloads of only 12 to 15 children.

[23]This mode of operation may contribute to some judges' complaint that caseworkers fail to refer parents to all the services they need, and to sequence these services appropriately. For example, it may not be realistic to expect a mother who just entered a drug treatment program to attend parenting classes until she has made some progress in treatment. Furthermore, caseworkers sometimes refer a parent to drug treatment programs located far from their home or workplace. When services are limited, however, it can be very difficult for caseworkers to refer parents to services that are both appropriate and convenient.

[24]CWLA surveyed state child welfare agencies in 1997 and found that, even though about two-thirds of parents need drug or alcohol treatment services, agencies had the capacity to serve (either directly or through contracted services) only about half of those parents, and many could not be treated in a timely manner.

[25]Staff with Target Cities projects in Cook and Los Angeles Counties said that waiting lists continue to be a problem, particularly for certain types of drug treatment such as residential and methadone programs. The Target Cities Program, federally funded through the Center for Substance Abuse Treatment (CSAT) within HHS, works to improve treatment delivery systems in metropolitan areas by establishing central intake, assessment, and referral systems.

effective as extended residential care,[26] some treatment providers said that many mothers whose children are in foster care require some period of residential treatment to stabilize before being referred for outpatient care.[27]

Experts on drug treatment generally believe that, following either residential or outpatient treatment, recovering parents need after-care services.[28] According to treatment providers in our case study locations, after-care services related to drug and alcohol treatment are particularly important in foster care cases in which timely permanency decisions are being emphasized. These services, however, are not always provided to parents with children in foster care. After-care services for these parents might include ongoing caseworker visits to follow up with parents after they have been reunified with their children, to ensure their participation in self-help groups,[29] and to provide referrals for additional social services. According to some agency officials, if after-care is not provided to parents who have completed drug treatment, judges may delay reunifying them with their children. These families often live in drug-infested neighborhoods. Without after-care services, these parents may be more likely to relapse, and their children may be more likely to re-enter foster care.

[26]GAO/HEHS-98-72, Mar. 27, 1998. Evidence from the recent Drug Abuse Treatment Outcome Study (DATOS), initiated in 1989 by the National Institute on Drug Abuse (NIDA), confirmed that reported reductions in cocaine use were similar for outpatient and residential settings when clients remained in treatment for at least 3 months. Researchers point out, however, that because more clients with severe substance abuse problems may be in residential treatment settings, such comparisons are problematic.

[27]Even when parents enter residential treatment, funding constraints have led to reductions in the length of some residential treatment programs, raising concerns among treatment providers that parents may not be able to make sufficient progress in these shorter lengths of time. As a result, some treatment providers are offering more intensive services in these shorter residential programs, or developing intensive outpatient programs. Intensive outpatient treatment typically involves participation for a minimum of 9 treatment hours per week during the day or evening, with minimal disruption to work and family life, and promotes the integration of what is learned in treatment to daily life. Intensive outpatient treatment can extend over long durations, often measured in months rather than days or weeks.

[28]After-care services related to drug and alcohol treatment are designed to provide clients with continuing support, and offer a transition from an intensive level of treatment to nontreatment phases of recovery. After-care services can include case management; individual, group, or family therapy; and monitoring and drug testing, among other services.

[29]Self-help groups, such as Narcotics Anonymous and Cocaine Anonymous, provide individuals recovering from drug and alcohol addictions the opportunity to meet regularly to discuss their past difficulties and seek and offer support and advice. These programs are conducted by the members themselves, rather than by professionals.

Foster Care Agencies Face Challenges in Monitoring Parents' Progress in Treatment

Another challenge facing foster care agencies arises from the problems in monitoring parents' progress in drug or alcohol treatment. Detailed information on parents' progress in treatment is not always available to judges when determining whether a family should be reunified, reunification efforts should continue, or some other permanency goal should be pursued. This information may not always be provided to judges because foster care agencies do not always communicate regularly with treatment providers. Judges told us about instances in which permanency decisions were delayed because attorneys did not have access to the treatment provider's records of the parent's participation or because reports from the caseworkers did not include sufficient information about the parent's progress in treatment. Again, high caseloads and turnover among both caseworkers and attorneys exacerbate the problem. Caseworkers may have limited time to discuss in detail a parent's progress with the treatment provider, just as attorneys may have limited time to review reports on parents' progress in treatment in advance of a permanency hearing. Confidentiality requirements to protect the privacy of clients in drug or alcohol treatment may also interfere with obtaining information about parents' progress in treatment. Some foster care agencies ask parents, before they enter treatment, for their written consent to obtain information on their progress in treatment. If agencies do not obtain written consent, a court order may be needed to access this information.[30]

When information on parents' progress in treatment is not sufficiently detailed or not provided on a timely basis, permanency decisionmaking may be delayed because the judge does not know if it is safe to return children to the custody of their parents. Because relapse is common, judges also need information about the significance of any relapses in terms of the parents' overall progress toward recovery. For example, providing results of periodic, random drug tests may indicate a brief relapse followed by a long period of abstinence, indicating overall reduced drug use. In addition, without this information, parents are able to manipulate or "game" the system, and judges may not be able to determine when laws on permanency decisionmaking for cases involving parental substance abuse apply. Furthermore, judges may have difficulty

[30]Under 42 C.F.R. §2.63, without parents' written consent, disclosure can only be authorized by a court order to "protect against an existing threat to life or serious bodily injury," which includes "circumstances which constitute suspected child abuse and neglect." To obtain a court order authorizing disclosure, the foster care agency must file an application with the court, at which time notice to the parent must be served; and the parent can file a written response. Courts may differ in their interpretation as to whether or not disclosure of treatment information is warranted in these cases.

determining if agencies have made reasonable efforts to help reunify the family.

Manipulative behavior was described by child welfare officials and treatment providers as often characteristic of addicts who are consumed by their need to use drugs and alcohol. When parents are aware that their progress in treatment is not being closely monitored, they may falsely claim to be in treatment and making progress in an attempt to prevent the court from moving toward terminating their parental rights. Caseworkers also told us that parents sometimes try to manipulate the system to extend the period during which the permanency goal is family reunification by entering treatment just before hearings, only to drop out of treatment immediately after. A treatment provider characterized this behavior as a negative consequence of how permanency decisions have historically been made. These parents are often aware that, in the past, years have elapsed before some permanency decisions were made because the period of family reunification was extended, thereby providing parents with additional opportunities to recover from their addictions and regain custody of their children.

Judges also need information about parents' progress in drug treatment, as well as their drug abuse and treatment history, to determine when existing state laws governing permanency decisionmaking in these cases apply. Thirty states have laws specifying that parental substance abuse is either a consideration in or grounds for terminating parental rights, and a number of states are very specific in how they address permanency decisionmaking for cases involving parental substance abuse. For example, California law does not require foster care agencies to offer reunification services if the parent has a serious and longstanding substance abuse problem and has resisted treatment during the previous 3 years or has failed or refused treatment at least twice.[31] Illinois law does not require the foster care agency to make efforts to reunify the family if the foster child is at least the second child of that parent to have been prenatally substance-exposed and the mother had been given the opportunity to participate in treatment when the first child was prenatally

[31]California law does not require that family reunification efforts be provided when the parent has a history of extensive, abusive, and chronic use of drugs or alcohol, and has resisted treatment during a 3-year period immediately prior to the filing of the petition which brought the minor to the court's attention, or has failed or refused to comply with a program of drug or alcohol treatment described in the case plan on at least two prior occasions, even though the programs identified were available and accessible. Cal. Welf. & Inst. Code § 361.5(b)(12).

exposed. State laws on permanency decisionmaking for foster care cases involving parental substance abuse are discussed further in appendix V.[32]

Given the lack of consensus as to what constitutes reasonable efforts to help reunify families,[33] judges also need detailed information about what foster care agencies have done to help parents recover from their drug or alcohol addictions in order to determine whether reasonable efforts have been made.[34] According to some officials, if judges do not have sufficient information to determine whether reasonable efforts have been made, they may extend the family reunification period. When drug and alcohol treatment resources are limited within a community and this delays a parent's entry into drug treatment, foster care agencies may also hesitate to begin proceedings to terminate parental rights.[35]

Barriers Hinder Foster Care Agencies' Ability to Quickly Achieve Adoption or Guardianship

When family reunification efforts fail, foster care agencies face several barriers to quickly achieving adoption or guardianship in cases involving parental substance abuse. Before parental rights can be terminated,[36] foster care agencies are required to attempt to locate any parents whose whereabouts are unknown, notify parents of the court's intent to terminate their parental rights, and provide reunification services to parents who are located and interested in regaining custody. The whereabouts of substance abusing parents—particularly fathers—are often unknown, perhaps because they lack a stable residence, are involved in drug-related activity

[32]Some of these more prescriptive state laws are controversial. Some judges find these statutes helpful for guiding permanency decisions as long as they retain discretion in decisionmaking. Some drug treatment providers criticized the more prescriptive provisions because their experience working with substance abusers has shown that past behavior may not always predict future behavior. In contrast, some judges and treatment providers agreed that federal and state laws that place certain time limits on permanency decisionmaking may motivate some parents to comply with their case plans.

[33]A national advisory panel, convened in 1995 by the American Bar Association's Center on Children and the Law and the National Child Welfare Resource Center for Organizational Improvement at the University of Southern Maine, recommended that the federal government not develop a set of "core" reunification services because of the "political unpopularity" of federal mandates in general and differences between states in terms of the needs of their clients.

[34]In January 1992, the National Council of Juvenile and Family Court Judges published its Protocol for Making Reasonable Efforts to Preserve Families in Drug-Related Dependency Cases, which provides questions for judges to ask caseworkers and themselves when determining whether reasonable efforts have been made in cases involving parental substance abuse.

[35]Several judges we interviewed also criticized case plans for not being specific or rigorous enough to enable judges to determine whether the agency has made reasonable efforts to reunify the family, or whether there has been a real change in a parent's behavior or improvement in their ability to parent.

[36]Parental rights must be terminated before a child can be adopted. Each state has its own statutory provisions for the dissolution of the parent-child relationship. While reunification services generally must be offered to fathers, unwed or "putative" fathers may only be entitled to receive notice of an action to terminate their parental rights and may have no right to block an adoption.

themselves, or are incarcerated. In addition, mothers sometimes try to delay proceedings to terminate their parental rights by identifying the probable father just before a TPR hearing.[37] Consequently, foster care agencies often overlook fathers and their extended families as potential adoptive resources, according to one judge, because the whereabouts of fathers are so often unknown. Termination of parental rights also may be delayed when a parent for whom reunification services must be provided is incarcerated or repeatedly disappears, which is common among foster care cases involving parental substance abuse. This can disrupt the provision of reunification services, and parents may then appeal a decision to terminate parental rights on the grounds that the agency failed to make reasonable efforts to reunify the family.

Health problems of foster children can be another barrier to adoption. In a prior study we found that over half of the young foster children in selected locations in 1991 had serious health problems—such as fetal alcohol syndrome, developmental delays, and HIV—which may have been caused or compounded by prenatal substance exposure.[38] However, some experts believe that caution should be used when predicting adverse developmental outcomes on the basis of prenatal substance exposure because these outcomes are greatly affected by the quality of health care and the developmental supports the child receives and the social environment that the child is exposed to. Other barriers to adoption include the age of the child and behavioral and emotional problems that many children have as a result of abuse or neglect.

Placement of foster children with relatives may also present a barrier to adoption in cases involving parental substance abuse. In both California and Illinois, we found that over half of the foster children in our survey with substance-abusing parents were placed with relatives. In these cases, when reunification efforts were discontinued and the permanency goal was changed to something other than adoption, the reason often given for not pursuing adoption was that the relatives with whom the child was placed did not want to adopt the child. There are many different reasons why relatives, in general, might not want to adopt these children. According to some foster care caseworkers and agency officials, relatives may fear that if they adopt these children, the parents will no longer be motivated to recover. Relatives may also fear the damage that terminating

[37]HHS officials recently told us that several states have pilot programs to initiate searches for noncustodial or absent parents upon a child's initial entry into foster care. Louisiana passed legislation that could prevent delays in hearings to terminate parental rights when a parent appears and asks for custody of the child after being missing for a period of time.

[38]GAO/HEHS-94-89, Apr. 4, 1994.

parental rights will have on their own relationship with the parents of these children. Relatives may also be reluctant to assume legal guardianship of the children placed with them without financial assistance to help support them.

Adoption staff at our case study locations also raised concerns regarding the limited number of adoptive homes that may be available in these cases, although they believed current outreach and recruitment efforts might help increase the number of potential adoptive homes, particularly if children were freed for adoption when they were younger.[39] Demand for adoptive resources, however, is likely to increase because many foster care cases involving parental substance abuse have been in the system for long periods of time, and states are now required to begin legal proceedings to terminate parental rights in large numbers of these cases. Among the cases in our survey involving parental substance abuse in which family reunification was no longer the goal, children had been in foster care for an average of about 5-1/2 years in California and over 4 years in Illinois.[40] (See table III.5 in app. III.)

On the basis of our survey, we estimate that about 61,700 children in California and 43,100 in Illinois had been in foster care for at least 17 months as of September 15, 1997,[41] and in each state, over 60 percent had parents who were substance abusers. (See fig. 5.) As such, these cases could fall under the new federal requirement to terminate parental rights.[42] Parental rights had already been terminated as of September 15, 1997, for at least one of the parents in 19 percent of the cases in California and 27 percent of the cases in Illinois that involved parental substance abuse.

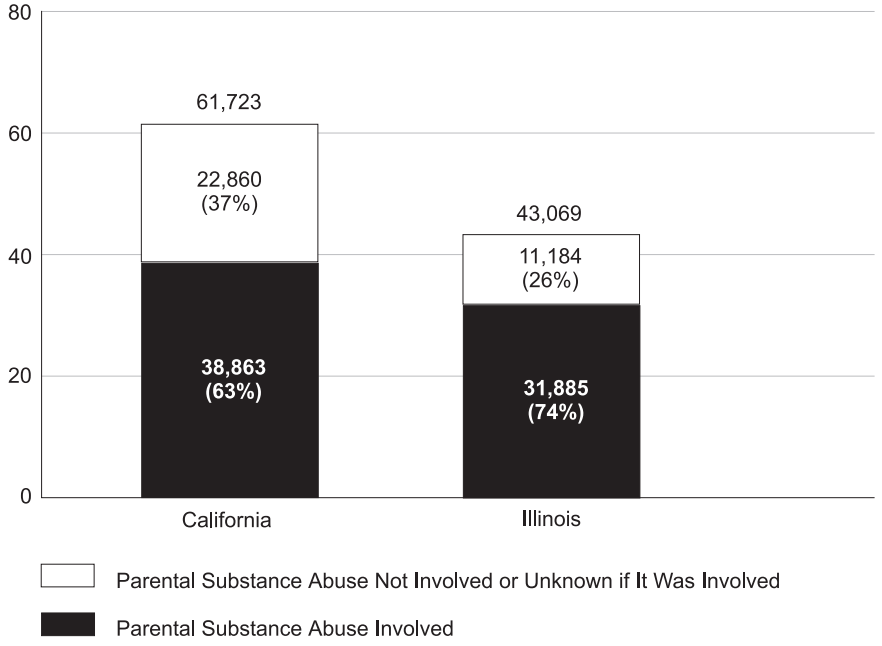
[39]The Howard M. Metzenbaum Multiethnic Placement Act of 1994 (P.L. 103-382) requires states to make diligent efforts to expand the pool of adoptive parents.

[40]Among these cases, there was no statistically significant difference between the average length of time that children whose parents were substance abusers and those whose parents were not substance abusers had been in foster care. In cases involving parental substance abuse in which family reunification was no longer the goal, the average length of time that reunification had been the goal was about 19 months in California and 22 months in Illinois.

[41]The clock for determining the 15-month TPR requirement begins on the date the case was adjudicated and the child was determined to have been abused or neglected, or 60 days from the date that custody was removed from the parents, whichever came first. We based our estimates on a more conservative 17-month criterion. See appendix I for a detailed description of how we arrived at our estimates.

[42]Even if these states choose to exclude cases in which foster children are placed with relatives, a total of about 50,600 foster children in these states combined could fall under the TPR requirement.

Figure 5: Estimated Number of Cases of Children in Foster Care at Least 17 Months and Number Known to Involve Parental Substance Abuse



Notes: Includes some foster care cases in which parental rights had already been terminated for at least one parent as of September 15, 1997, and may include cases in which a TPR petition has been filed but parental rights have not yet been terminated. See also table III.6 in app. III.

Source: GAO survey of open foster care cases in California and Illinois.

Initiatives Addressing Parental Substance Abuse Seek to Achieve Permanency for Children

Some locations have launched initiatives that seek to improve the prospects for recovery and family reunification when parental substance abuse is involved. These initiatives involve linkages between foster care agencies, drug treatment providers, and sometimes the courts and other organizations.[43] Some locations are undertaking other efforts to more quickly achieve other permanency outcomes for children when the decision is made to end family reunification efforts. Some locations are also implementing programs to encourage more relatives of children in foster care to adopt or assume legal guardianship of them. While these

[43]Other programs being implemented in some locations reflect the philosophy that it is more effective to address parents' substance abuse problems before their children come into foster care. The target population of these programs is pregnant mothers with substance abuse problems, or mothers who deliver prenatally drug-exposed infants. For example, Cleveland, Ohio, has launched an initiative bringing child welfare and drug treatment agencies together to prevent prenatally drug-exposed infants from coming into foster care and to help parents who have already lost custody of their children recover in order to reunify these families.

efforts to more quickly achieve other permanency outcomes for children are not specific to cases involving parental substance abuse, they may be useful in achieving timely permanency outcomes in these foster care cases.

Initiatives Seek to Improve Prospects for Recovery and Family Reunification

Some locations have launched initiatives to improve the prospects for family reunification when parental substance abuse is involved. These initiatives are highly collaborative, call upon the expertise of drug treatment professionals to get parents into treatment as quickly as possible, and involve close monitoring of parents' progress to help judges make more timely permanency decisions. Although these initiatives show promise, they are too new to show definitive results.

The Illinois Expansion Initiative

The Illinois Expansion Initiative[44] is a collaborative effort between the state child welfare and substance abuse treatment agencies to help substance abusing parents recover in order to be reunified with their children. A joint steering committee developed procedures to better enable the child welfare agency to screen for substance abuse problems and make referrals to a drug treatment provider. This screening tool helps caseworkers identify substance-abusing parents even when they lack training or experience in substance abuse. Using this tool, the caseworker can determine—on the basis of visual observation (such as signs of intravenous drug use or poor personal hygiene), statements made by the client (such as whether the parent has missed work because of a hangover), and facts associated with the case (such as drug-related criminal charges)—whether the parent should be referred for an assessment by a qualified substance abuse counselor.

If a substance abuse problem is indicated, referrals to a treatment provider for a full assessment must be made by the child welfare agency within 1 working day. The treatment provider is required to begin treating the parent within 3 working days after the assessment. Through cross-training, caseworkers learn about the nature of alcohol and drug addiction, and drug treatment providers are trained in child welfare issues. Outreach workers, who are drug treatment professionals, visit each parent referred by the child welfare agency at their home, help motivate the parent to get into treatment, and provide ongoing support to help the parent apply the lessons learned in treatment to day-to-day life. Any parent referred for an assessment must sign a written consent form that gives the foster care

[44]The Illinois Initiative was established in 1995 as an outgrowth of Project SAFE (Substance and Alcohol-Free Environment), a federal demonstration project that was piloted in selected locations in Illinois in 1986 and then expanded to other locations across the state in later years.

agency access to information regarding the parent's attendance and progress in treatment.

Joint strategies to expand treatment services to meet the needs of mothers in high-risk communities, including a range of treatment settings, are also part of this initiative. Through this initiative, the two state agencies are working to develop a full range of treatment settings—including detoxification, residential, and intensive outpatient programs. Parents are referred to the appropriate treatment program based on the nature of their addiction, whether residential treatment is necessary because the home environment is not conducive to recovery, and the availability of treatment settings within that community.

Similarly, services to address the multiple needs of substance-abusing parents and their families are being explored, including a parenting program that provides parents opportunities for ongoing interaction with their children and thereby better enables treatment providers to provide meaningful information to the courts on mothers' ability to parent. Reports on clients' progress in treatment are routinely submitted to the child welfare agency by treatment providers and are used by the courts for permanency decisionmaking.

Reno Family Drug Court

The Reno Family Drug Court[45] is a court-driven effort to facilitate the recovery of substance-abusing parents of foster children in order to reunify these families. Collaborating agencies include the family court, the child welfare agency, local drug treatment providers, corrections agencies, state and county welfare agencies, and a private foundation. The family drug court serves parents whose children either may be or already have been removed from their custody and placed in foster care because of the parents' substance abuse problems. Some of these parents also face criminal prosecution related to their involvement in substance abuse. Within 72 hours of the child's removal, these cases are brought before the family drug court and a decision is made as to whether or not the parent is a good candidate for this program primarily on the basis of the parent's personal motivation to recover and willingness to provide written consent to share information regarding progress in treatment. The caseworker develops an individualized case plan based on a comprehensive assessment of the family's needs with input from collaborating agencies and all attorneys involved. The parent is typically referred to either a residential or an intensive outpatient program. Some parents are referred

[45]The Washoe County Family Drug Court, in Reno, Nevada, was initiated in 1993, in response to high rates of drug and alcohol abuse and the growing abuse of methamphetamines in this casino industry area.

to intensive outpatient treatment programs, but "hard-core" addicts are often referred to residential treatment programs. After a minimum of 3 months in residential treatment, these parents may be placed in halfway houses or transitional housing for an additional 6 to 9 months.

In addition to the foster care agency caseworker, the parent is also assisted by an "integrated service" case manager, funded through the Tru Vista Foundation. This case manager facilitates collaboration between the agencies and works to obtain the community resources needed to support the parent's individualized case plan, including counseling, domestic violence support groups, parenting training, transportation services, vocational and educational training, and self-help groups to help the parent remain drug-free.

To facilitate timely permanency decisionmaking, the family drug court convenes biweekly to review parents' progress in these cases. Before each hearing, a multidisciplinary drug court team confers on the parent's progress over the previous 2 weeks. The team comprises the caseworker, treatment provider, judge, district attorney, defense attorney, and Court Appointed Special Advocate (CASA). The latter is a volunteer who serves as an ombudsman for the court and advocates for the child's interests. Frequent random drug testing is imposed, and parents receive positive feedback for any progress achieved. Sanctions, such as short jail sentences or community service time, are imposed if parents test positive for drugs or have unexcused absences from treatment programs. If the parent fails to exhibit commitment to treatment, the case reverts to the usual court review process for child welfare cases, or to the adult offenders' court when criminal charges are involved. The target for graduating from the program is 1 year, although the program may include a period of after-care of up to 6 months, during which time the court continues to monitor the case.

Delaware's Multi-Disciplinary Treatment Team Initiative

Another initiative, Delaware's Multi-Disciplinary Treatment Team, is a 3-year demonstration project, accepted by HHS in January 1996, featuring teams comprising caseworkers from the child welfare agency and substance abuse counselors from local treatment providers. Several substance abuse counselors are co-located with caseworkers in three county child welfare offices in the state. When parents come to the attention of the child welfare agency, substance abuse counselors help caseworkers assess the severity of the addiction, confront the family's denial of the problem, and make referrals to the most appropriate treatment providers. These substance abuse counselors accompany

parents to treatment programs and work closely with parents to help keep them engaged in treatment. Because the state has a managed care system of Medicaid services, substance abuse counselors also help the families navigate the system to help ensure that parents receive appropriate treatment services. Many parents receive only outpatient drug treatment because of difficulties in getting authorization for parents to enter residential treatment under the managed care system.[46] Substance abuse counselors monitor parents' progress in treatment through the linkages they maintain with local drug treatment providers and assist caseworkers in communicating information about treatment progress to the courts to help judges make decisions about reunifying parents with their children.

Initiatives Are Too New to Show Definitive Results

Because these initiatives are relatively new, there are only preliminary results to date. However, the initial results from internal evaluations of these initiatives are promising in terms of both improving prospects for family reunification in cases involving parental substance abuse and helping agencies make more timely decisions about when to end family reunification efforts in order to pursue some other permanency outcome. For example, preliminary results of the Illinois Expansion Initiative indicate that participants reduced their drug and alcohol use more than those who did not receive enhanced services through the initiative.[47] Nearly 50 percent of 132 parents in the Reno Family Drug Court initiative graduated from the program. Many parents who graduated from the program were reunified with their children, while some parents chose to relinquish their parental rights. According to a court official, the latter are also success stories because the program helped these parents understand that, because of their inability to recover from their drug addictions, their children would not be safe in their custody.[48] The preliminary results of the Delaware Multi-Disciplinary Treatment Teams show that the proportion of total foster care costs expended on substance abuse cases decreased in two of the three child welfare offices using multidisciplinary

[46]An early evaluation of the Delaware project identified problems accessing treatment, particularly residential treatment, through the state's managed care system of Medicaid services.

[47]Comparative rates of family reunification from the Illinois Expansion Initiative are not yet available.

[48]A number of drug court programs across the country also mandate treatment instead of incarceration for generally nonviolent offenders whose current involvement with the criminal justice system is due, primarily, to their substance addiction. In addition to reducing drug use and recidivism, these programs have also helped parents of foster children achieve family reunification. A study of California's Options for Recovery (OFR) treatment program, a comprehensive program designed for pregnant and parenting women, found that a higher percentage of women who were required to enroll in OFR by either the criminal justice system or child protective agencies completed treatment compared with women who enrolled in OFR voluntarily.

teams and increased in the three offices (designated as the control group) not using multidisciplinary teams.[49]

Strategies to Speed Up Permanency and Increase Adoptions and Legal Guardianships

A number of state and local efforts also seek to speed up permanency decisionmaking or encourage relatives of children in foster care to adopt or assume legal guardianship. While these efforts are not specific to cases involving parental substance abuse, they may be useful for cases involving parental substance abuse because many of these parents may not be able to recover in a timely manner. As such, a significant number of adoptive parents or legal guardians may be needed for these children.

Concurrent Planning

Concurrent planning is a strategy that allows caseworkers to work toward reunifying families, while at the same time developing an alternate permanency plan for the child in case family reunification cannot be achieved in a timely manner. Caseworkers emphasize to the parents that if they do not adhere to the requirements set forth in the case plan, their parental rights can be terminated.[50] As a result, family reunification might be achieved more quickly for some children if parents make a more concerted effort early-on to recover from their addictions and make other changes needed for their children to be safely returned to their custody. If not, concurrent planning enables caseworkers to more quickly achieve an alternate permanency outcome when the decision is made to end family reunification efforts.

Some foster care agencies are being encouraged, as part of concurrent planning, to develop tools to assess the prognosis for family reunification. A wide range of indicators may be considered in assessing the prognosis for reunification, which may apply in cases involving parental substance abuse. For example, local foster care agencies may consider factors such as the parent's history of abusing his or her own children or the parent having grown up in foster care. Some indicators associated with a poor prognosis for family reunification are relevant to cases involving parental substance abuse, such as if the parent's "only visible support system and only visible means of financial support is found in illegal drugs,

[49]This evaluation identified several problems that the multidisciplinary teams are encountering. For example, substance abuse counselors are finding these parents to be more resistant to treatment than anticipated; referrals of cases to counselors have been "sporadic" because of the lack of procedures for screenings and referrals; and cases may potentially remain open even when parents fail to cooperate because of the lack of clear criteria for closing cases.

[50]We previously reported that concurrent planning is one of a number of state efforts to hasten the permanency planning process and reduce the length of time children spend in foster care in Foster Care: State Efforts to Improve the Permanency Planning Process Show Some Promise (GAO/HEHS-97-73, May 7, 1997).

prostitution, and street life."[51] When a poor prognosis for family reunification is indicated, foster care agencies in California should now try to place children as early as possible in foster homes in which the caregiver is willing not only to support the agency's efforts to reunify the child with his or her parents but also to provide a permanent home if reunification efforts fail.[52]

Through the use of concurrent planning, some states are beginning to achieve reductions in the length of time that children spend in foster care. Given the difficulties encountered in reunifying families when parental substance abuse is involved, many of these children may need adoptive parents or legal guardians. For example, in Colorado, the state legislature passed an expedited permanency bill in 1994 requiring that any child under 6 years of age must be placed in a permanent home no later than 12 months after entering foster care. Several counties have since reported that permanency is being achieved earlier for these children compared with children who came into foster care prior to the implementation of the expedited permanency law.[53] However, one county official in Colorado told us that because of the difficulties the county faces in reunifying families when parental substance abuse is involved, priority is given to finding relatives and other foster care placements that can provide permanent homes for these children as soon as possible.

Programs to Encourage Relatives to Adopt or Assume Legal Guardianship

To improve the prospects of achieving permanency for more foster children, some locations have implemented programs to encourage individuals to adopt or assume legal guardianship. These programs are particularly applicable when children are placed with relatives, as is the case for many children in foster care. When the relatives of foster children are willing to make a long-term commitment to them but do not wish to have the relationship between the parents and children legally severed, permanency can be achieved through open adoption. For relatives who do not wish to adopt and are also in need of financial assistance to help support the children placed with them, subsidized legal guardianship may be a viable permanency option.

[51]This indicator appears in a tool for assessing the prognosis for reunification developed by the National Resource Center for Permanency Planning, Hunter College School of Social Work, New York, N.Y. Local foster care agencies in California have been encouraged to adopt tools such as these to facilitate their concurrent planning efforts.

[52]Dual certification of homes for both foster care and adoption has been used by some foster care agencies even if concurrent planning is not conducted. By placing children with foster parents who are also approved as adoptive parents, the number of placements is minimized, children's developmental needs are met, and potential adoptive parents have the opportunity to begin caring for children as early as possible.

[53]Three counties for which outcome data are available have achieved permanency, mostly through family reunification or adoption by a relative, for a greater percentage of children within 12 months.

Open adoption programs, in which parents retain visitation rights, have been implemented in some locations to make adoption more appealing to relatives. For example, California recently enacted legislation that allows open adoptions with relatives.[54] Under this program, biological parents or other relatives of the child can enter into a written agreement for continued contact or sharing of information between all parties involved.[55] To encourage individuals to assume legal guardianship of children in foster care, many states provide subsidies to those who need financial assistance. Subsidized guardianship programs in California, Delaware, Illinois, Maryland, and North Carolina are authorized under title IV-E foster care waivers. HHS approved these subsidized guardianship programs in 1996 and 1997 as child welfare demonstration projects. A determination of the caregiver's need for the subsidy to support the placement is made when determining eligibility.[56] In a recent study, Illinois projected that about 5,700 children would be placed in subsidized legal guardianships in the first 2 years under its program.

Conclusions

The Adoption and Safe Families Act of 1997 establishes rigorous new requirements governing state legal proceedings to terminate parental rights for children who have been in foster care for at least 15 of the most recent 22 months. These requirements impose on foster care agencies the difficult tasks of attempting to reunify these families within shorter time frames than have been allowed historically and finding adoptive homes for children when family reunification efforts fail.

To accomplish these tasks, foster care agencies will need to overcome a number of administrative challenges, such as inadequate links with drug and alcohol treatment providers and inadequate monitoring of parents' progress in treatment. Information about parents' progress in treatment is essential for judges to make informed permanency decisions within the time frames specified by the law, whether they decide to reunify these children with their parents or pursue some other permanency outcome. To collect this information, foster care agencies must closely monitor parents' progress in treatment. If a parent's progress in treatment is not adequate to

[54]California Assembly Bill 1544 was signed by the Governor on October 8, 1997.

[55]Foster care agency officials told us that open adoptions might not appeal to some potential adoptive parents, particularly when they are unrelated to the biological parent, because the adoptive parent may not want to have any contact with the biological family.

[56]While states vary regarding the level of support provided for subsidized guardianship placements, some states set the level of support for these placements at the current foster care rate. Subsidy agreements are reassessed on an annual basis to determine continued eligibility for payments to support these placements.

ensure a child's safety—if the child was reunified with the family—this information can help support the judge's decision to end family reunification efforts and terminate parental rights in order to pursue adoption for that child.

If agencies wish to maximize prospects for family reunification in these cases, they must maintain strong linkages with drug treatment providers. In addition to making it easier for foster care agencies to monitor their progress, these linkages could help parents obtain appropriate treatment quickly. Some locations are experimenting with cooperative approaches to case management, involving foster care agencies, drug treatment providers, and the courts. These cooperative approaches may respond to some of the problems we identified in our case studies that can impede recovery and, ultimately, family reunification. Foster care agencies could work to develop stronger links with drug treatment providers, despite the difficulties involved.

Some factors associated with drug and alcohol addiction are outside the control of foster care agencies, but agencies must deal with them nonetheless. Even when provided with treatment opportunities, some parents will not break free of drug dependency. Thus, some foster care agencies are developing strategies to quickly achieve other permanency outcomes for children when family reunification efforts fail. Concurrently planning for both family reunification and an alternate permanency outcome may help ensure that children are placed in safe, permanent homes in a timely manner. This may reduce the time it takes to identify an adoptive parent and terminate parental rights. To the extent possible, children should be placed with foster parents who are willing to adopt them, thus preventing children from languishing in foster care. Pursuing ways to encourage foster parents to assume legal guardianship if they are unwilling to adopt may also help achieve timely permanency outcomes for more children in foster care.

Agency Comments and Our Evaluation

We provided HHS, as well as the appropriate state social services agencies in California and Illinois, with the opportunity to comment on a draft of this report. HHS, the California Department of Social Services, and the Illinois Department of Children and Family Services generally agreed with our findings and believed we had described issues that are critical to the child welfare system. Each of the agencies provided technical comments that we incorporated into our report where appropriate. Appendix VI contains HHS' comments on the draft of this report.

We will send copies of this report to the Secretary of Health and Human Services and program officials in the states and localities reviewed. We will also send copies to all state child welfare program directors and make copies available to others upon request. Please contact me at (202) 512-7215 if you or your staff have any questions. Other GAO contacts and contributors are listed in appendix VII.

Sincerely yours,

Mark V. Nadel
Associate Director
Income Security Issues

Contents

Tables

Figures

Abbreviations

AFCARS	Adoption and Foster Care Analysis and Reporting System
CASA	Court Appointed Special Advocate
CSAT	Center for Substance Abuse Treatment
CWLA	Child Welfare League of America
DATOS	Drug Abuse Treatment Outcome Study
DRA	Delegated Relative Authority
FAS	fetal alcohol syndrome
GPRA	Government Performance and Results Act
HHS	Department of Health and Human Services
LSD	lysergic acid diethylamide
NIDA	National Institute on Drug Abuse
OFR	Options For Recovery
PCP	phencyclidine hydrochloride
Project SAFE	Substance and Alcohol-Free Environment Project
SIDS	sudden infant death syndrome
TPR	termination of parental rights

Scope and Methodology

Survey Methodology

To obtain information about the extent and characteristics of parental substance abuse among foster care cases, as well as information about the drug and alcohol treatment parents receive and the length of time their children spend in foster care, we conducted a survey of open foster care cases in California and Illinois. The foster care caseloads for these two states combined account for about one-quarter of the entire foster care population nationwide.

Survey Design and Limitations

In each state, a simple random sample of open foster care cases was selected to represent the general population of foster care cases statewide. These cases were in the system on June 1, 1997, and had been there continuously since March 1, 1997.[57] These are referred to as "point-in-time" or cross-sectional samples. They are intended to represent the entire population of open foster care cases in each state during the time period specified. They allow us to make statements about the experiences of all foster children in the foster care caseload during that time. Cross-sectional samples, however, do not capture the experiences of all foster children that enter the system. Foster children who spend relatively short periods of time in the system may be under-represented in cross-sectional samples, while children who spend more time in foster care may be over-represented. Furthermore, while survey results based on these samples can be generalized to the population of open foster care cases during the specified time frame in each state, these samples are not meant to represent the foster care population nationally or in any other state.

Subsequent to drawing our samples, we learned that 22 of the sampled cases from California and 2 from Illinois had not actually been in foster care continuously from March 1, 1997, through June 1, 1997. We excluded these cases from our samples. An additional 57 cases in the California sample and 17 in the Illinois sample were excluded from our survey because information provided in the questionnaire indicated that they did not remain in the foster care system continuously from June 1, 1997, through September 15, 1997. We used the proportions of each of these types of cases in each of our samples to estimate the number of cases in each state's foster care population that would have fallen into these two categories. The initial and adjusted population and sample sizes and survey response rates are shown by state in table I.1. The adjusted populations are our best estimates of the number of foster care cases in each state that were in the system continuously from March 1, 1997, through September 15, 1997.

[57]These samples were also used for another study GAO was conducting on kinship care.

Table I.1: Initial and Adjusted Population and Sample Sizes and Response Rates for Our Survey of Open Foster Care Cases

State	Initial population size[a]	Initial sample size	Adjusted sample size	Adjusted population size	Survey responses	Survey response rate
California	100,044	401	297	74,133	227	76%
Illinois	51,967	401	376	48,745	292	78%

[a]The number of children in each state's foster care population as of June 1, 1997, who had been in foster care continuously since at least March 1, 1997.

Data Collection

We designed a mail questionnaire to obtain information about individual foster care cases as of September 15, 1997.[58] We pretested the questionnaire with a number of foster care caseworkers in California and Illinois and revised it on the basis of pretest results. Appendix II contains a copy of the final questionnaire. We mailed a questionnaire for each case in our samples to the manager in the office handling that case who, in turn, passed it on to the assigned caseworker to complete. We conducted multiple follow-ups with office managers and caseworkers, both by mail and telephone, encouraging them to respond. In addition to using a mail questionnaire to collect information about the foster care cases in our samples, we obtained an automated file from each state that contained administrative data on each of the sample cases from that state.

Analysis of Survey Data

We calculated basic descriptive statistics for each variable in the questionnaire. Our analysis focused primarily on cases that involved parental drug or alcohol abuse. Each case in which one or both parents were required to undergo drug or alcohol treatment as part of the case plan for family reunification we classified as a case involving parental drug or alcohol abuse. Most of the percentage estimates we report were calculated using the number of cases for which there was a response to that item (other than "don't know") as the base. The results of our survey for each state are summarized in appendix III.

For analyses that involved a child's date of entry into foster care, we used the entry date contained in the state's administrative data file for the child rather than the date the caseworker indicated in the questionnaire. Thus, we used administrative rather than survey data to calculate the average length of time our cross-section of foster children had spent in foster care up until September 15, 1997.

[58]A single questionnaire was designed to collect information about parental substance abuse for this study and kinship care for another GAO study.

We also estimated the number of foster care cases in each state that would be subject to the requirement in the Adoption and Safe Families Act of 1997 to file a petition to terminate parental rights (TPR). These estimates were based on the number of cases in which the child had been in foster care for at least 17 months as of September 15, 1997. We used 17 months, rather than 15 months as specified in the law, because the clock for determining whether a case is subject to the TPR requirement actually begins on the date the case was adjudicated and the child was determined to have been abused or neglected, or 60 days after the date the child was actually removed from the parents' custody, whichever comes first.

Statistical Precision of Estimates

Because the estimates we report are based on samples of foster care cases, a margin of error or imprecision surrounds each one. This imprecision is usually expressed as a sampling error at a given confidence level. Sampling errors for estimates based on our survey are calculated at the 95-percent confidence level.

The sampling errors for the percentage estimates we cite in the letter and appendix III vary but do not exceed plus or minus 12 percentage points in the letter and plus or minus 10 percentage points in appendix III. This means that if we drew 100 independent samples from each of our populations—samples with the same specifications as those we used in this study—in 95 of them, the actual value in the population would fall within no more than plus or minus 12 percentage points of our estimates in the letter and plus or minus 10 percentage points of our estimates in appendix III. The sampling errors for the mean length of time in foster care (cited in table III.5 in app. III) and the mean length of time that family reunification was the goal (cited in footnote 40 of the letter) do not exceed plus or minus 7 months. The sampling errors for the estimates concerning the number of cases in which the child had been in foster care for at least 17 months (cited in fig. 5 of the letter and table III.6 of app. III) and the number of foster care cases that involved parental substance abuse (cited in the letter) do not exceed plus or minus 5,010 cases.

In general, there were comparatively few responses to survey questions concerning a foster child's father. Because estimates based on so few responses would be very imprecise, no population estimates were made with respect to most of the questions concerning fathers in either state.

Case Studies of Foster Care Systems

To provide information on the difficulties that foster care agencies and the courts face in making timely permanency decisions for foster children with substance abusing parents, we conducted case studies of foster care systems in three counties: Los Angeles County, California; Cook County, Illinois; and Orleans Parish, Louisiana. We focused on urban areas—two of which are in the states in which we conducted our survey of foster care cases—primarily because they have large foster care caseloads and large populations of substance abusers. In addition, we selected these particular counties because they provide a geographic mix of locations and have foster care laws and initiatives that address the issues of parental substance abuse and permanency decisionmaking.

In-Depth Interviews

In each of our case study locations, we conducted interviews with foster care program and policy officials, caseworkers, dependency court judges and attorneys, and drug treatment providers. Through these interviews, we obtained information on

- the extent and characteristics of parental substance abuse among foster care cases within these jurisdictions;
- local policies and practices for permanency decisionmaking and outcomes;
- how cases involving parental substance abuse typically navigate the system; and
- how the characteristics of these cases and existing laws, regulations, and policies may affect the progress of these cases toward family reunification or other permanency outcomes.

Case File Review

We also reviewed the case files from 10 foster care cases in each of our three case study locations to better understand and be able to illustrate the effect parental substance abuse has on permanency outcomes from foster care. See appendix IV for a description of selected foster care cases reviewed. We asked foster care officials in each of the three case study locations to select cases for our review on the basis of a number of criteria. We reviewed only case files from foster care cases in which the parents were required to undergo drug treatment as part of the case plan requirements for family reunification. To make sure that the information obtained reflected the current foster care environment and more recent substance abuse trends, we requested cases in which the child had entered foster care for the first time in 1990 or later and had been in foster care for at least 6 months. At each of our case study locations, we reviewed the

files for two cases with each of the following outcomes: (1) family reunification, (2) adoption, (3) guardianship, (4) currently in foster care, and (5) aged out of the foster care system after reaching age 18. We limited our review of cases that fell into the first three categories to those that had closed since January 1, 1996. We also limited our review of cases in the last two categories to those that had been open for about 3 years or more. Foster care officials were not always able to locate cases that fit all of our criteria. Consequently, our case file review included some cases that deviated somewhat from our criteria.[59]

We developed a standardized data collection instrument on which to record information from the case files we reviewed. We collected information about the foster child, such as age, date of and reasons for removal from the parents' custody, health conditions or behavioral problems, and the number and types of placements. We also collected information about the parents, such as the type of substances abused, the length of time they abused drugs or alcohol, criminal activities, mental and physical health problems or conditions, their compliance with case plan requirements, types of drug or alcohol treatment programs they entered, reasons for not completing treatment programs, and the number of times they relapsed. We also collected information about permanency decisionmaking in the case, such as when the goal changed from family reunification to an alternate permanency goal, if applicable;[60] if and when parental rights were terminated; and the permanency goal or outcome for this child at the time of our review. Although we also collected information in the file about the foster child's siblings, our focus in collecting data was on the foster child the case pertained to.

Review of State Laws

To provide information on existing laws that address reunifying families or achieving alternate permanency outcomes in a timely manner for foster children whose parents are substance abusers, we reviewed foster care statutes on ending family reunification efforts and terminating parental rights for each of the 50 states and the District of Columbia. We collected information on whether and how parental substance abuse is addressed in these statutes. We contacted states to verify that our findings were

[59]For example, a few cases had entered before 1990, or had exited shortly before January 1, 1996. In another case, the outcome of adoption had not been finalized at the time we conducted our case file review. Finally, in two cases (with the outcome of "currently in foster care" or "aged out of the foster care system"), the child had been in continuous care for at least 2 years but less than 3 years.

[60]After the goal changes from family reunification to some other permanency goal, typically reunification services, such as drug or alcohol treatment, are no longer provided by the foster care agency.

complete in instances in which we discovered other legal research that indicated different findings. The majority of our findings reflect the status of state foster care laws as of January 1, 1998; however, some of this work was conducted as early as April 1997, when we began our fieldwork.

Survey Questionnaire

Please detach and destroy this page before returning this questionnaire.

INTRODUCTION

The Congress has asked the U.S. General Accounting Office (GAO) to report on the experiences of foster children in kinship care as compared to those of foster children in other placement settings. It has also requested information about the implications of parental substance abuse for reunification and other foster care outcomes. To obtain this information, we have chosen a random sample of children in foster or substitute care in California and Illinois, and are asking the heads of foster care agencies or offices to have the caseworker most knowledgeable about each case complete this questionnaire.

The information you provide will help the Congress understand the current foster care system and whether changes to that system could further protect foster children. We will not use information from these questionnaires to assess your agency's compliance with policies or regulations.

Although this questionnaire appears lengthy, caseworkers who tested it found it easy and quick to complete. For most items, your knowledge of the case will be sufficient to answer the questions. Further, for most items, you will only need to check off boxes. Also, you will not need to complete all sections of the questionnaire. Caseworkers who tested this questionnaire took from 20 to 40 minutes to complete it. That was much less time than they expected it to take.

INSTRUCTIONS

The label in the next column identifies the child that we would like you to answer these questions about. Please provide information about the case as of September 15, 1997, unless otherwise instructed. When responding, you may consult the case file or others familiar with the case if they are able to provide a more precise answer.

Please return your completed questionnaire in the enclosed self-addressed envelope within 14 days of receipt. If you do not have this envelope, please send the completed questionnaire to:

U.S. General Accounting Office
Attn: Ann Walker
301 Howard Street, Suite 1200
San Francisco, CA 94105-2241

Please answer the questions in reference to this child:

PASTE LABEL HERE

If you have questions or comments, please call Ms. Ann Walker or Ms. Kerry Dunn at 415-904-2000.

Thank you for taking the time to assist us in meeting the information needs of the Congress about kinship care and other foster care issues.

DEFINITION OF TERMS

CHILD: Anyone in the foster care or substitute care system regardless of age. A "child," therefore, also refers to an infant or adolescent.

PARENT/MOTHER/FATHER: The person(s) from whose legal custody the child was removed. This person could be the child's biological or natural parent, or adoptive parent.

FOSTER CAREGIVER(S): Person(s) responsible for the day-to-day care of a child while that child is in the custody of the state. Foster caregivers can include caregivers in foster homes, "kinship" or "relative" care homes, house parents in group homes, and staff in institutions where the foster child resides.

FOSTER CARE EPISODE: A period of time that begins when the state assumes protective custody of a child and ends when the child is: reunified with the parent, adopted, emancipated, ages out or leaves the foster care system. A child can have more than one foster care episode. These questions refer to the foster care episode in effect on September 15, 1997.

FOSTER CARE PLACEMENT: Refers to the child's place of residence as of September 15, 1997. Placements include foster homes, "kinship" or "relative" care homes, group homes, and institutions. A child may have multiple placements within a single foster care episode.

N/A: Not applicable.

GAO Case Number |__|__|__|__|

BACKGROUND

Please enter the name and telephone number of the person completing this questionnaire. (PLEASE PRINT)

_____
Name

_____
(Area Code) Number

1. Were you this child's caseworker on September 15, 1997?

   1. ☐ Yes--> For how long?

      _____years _____months

   2. ☐ No--> What is your professional relationship to this child? (PLEASE DESCRIBE)

      _____

2. Is this child's date of birth recorded on the label located on the previous page correct?

   1. ☐ Yes
   2. ☐ No--> Enter correct date of birth

      _____
      Month / Day / Year

3. Was this child in the foster or substitute care system continuously from at least June 1, 1997 to September 15, 1997?

   1. ☐ Yes **(CONTINUE)**
   2. ☐ No **(STOP HERE! PLEASE RETURN THIS QUESTIONNAIRE. THE REST OF THE QUESTIONS DO NOT APPLY, BUT IT IS IMPORTANT TO RETURN THIS QUESTIONNAIRE.)**

THIS FOSTER CARE EPISODE

4. On what date did this foster care episode begin?

   _____
   Month / Day / Year

5. What was the **primary** reason for this child's removal? (CHECK ONE)

   1. ☐ Neglect
   2. ☐ Physical abuse
   3. ☐ Sexual abuse
   4. ☐ Emotional abuse
   5. ☐ Other (PLEASE SPECIFY)

      _____

6. Consider this child's placement as of September 15, 1997. About how long had this child been in this placement at that time?

   _____ years _____months

7. On September 15, 1997, in what type of foster care placement was this child residing? (CHECK ONE)

   1. ☐ In what your state classifies as kinship or relative care
   2. ☐ In a foster family home not classified as kinship or relative care (including "specialized" or "treatment" foster family home)
   3. ☐ In a group home or institution (GO TO QUESTION 23 ON PAGE 5)
   4. ☐ Other (PLEASE SPECIFY)

      _____

DESCRIPTION OF FOSTER CAREGIVER(S)

8. Consider this child's foster caregiver(s) as of September 15, 1997. Which of the following best describes the foster caregiver(s)? (CHECK ONE FOR EACH)

Caregiver 1

1. ☐ This child's relative as defined by your state
2. ☐ A person (not a relative) this child knew before entering foster care
3. ☐ Someone else

Caregiver 2

1. ☐ This child's relative as defined by your state
2. ☐ A person (not a relative) this child knew before entering foster care
3. ☐ Someone else
4. ☐ N/A, there was only one foster caregiver

9. Does one or both of the foster caregivers communicate in the primary language used by this child's parents? (CHECK ONE)

1. ☐ Yes
2. ☐ No
3. ☐ Don't know

10. Does one or both of the foster caregivers speak a language this child can understand? (CHECK ONE)

1. ☐ Yes
2. ☐ No
3. ☐ Don't know

11. Is one or both of the foster caregivers the same race or ethnicity as this child? (CHECK ONE)

1. ☐ Yes
2. ☐ No
3. ☐ Don't know

12. In your professional judgement, to what extent did this child know the foster caregiver(s) prior to this placement? (CHECK ONE FOR EACH)

Caregiver 1

1. ☐ To a very great extent
2. ☐ To a great extent
3. ☐ To a moderate extent
4. ☐ To some extent
5. ☐ To little or no extent
6. ☐ N/A, child was placed at birth

Caregiver 2

1. ☐ To a very great extent
2. ☐ To a great extent
3. ☐ To a moderate extent
4. ☐ To some extent
5. ☐ To little or no extent
6. ☐ N/A, child was placed at birth
7. ☐ N/A, there was only one foster caregiver

13. Did this child ever reside with one or both of the foster caregivers prior to this foster care placement? (CHECK ONE)

1. ☐ Yes
2. ☐ No
3. ☐ Don't know

14. What is the approximate age of the foster caregiver(s)? (CHECK ONE FOR EACH)

Caregiver 1

1. ☐ Less than 40 years old
2. ☐ 40 through 54 years old
3. ☐ 55 through 69 years old
4. ☐ 70 years of age or older
5. ☐ Don't know

Caregiver 2

1. ☐ Less than 40 years old
2. ☐ 40 through 54 years old
3. ☐ 55 through 69 years old
4. ☐ 70 years of age or older
5. ☐ Don't know
6. ☐ N/A, there was only one foster caregiver

15. Does one or both of the foster caregivers have a history of the following behaviors? (CHECK ONE FOR EACH)

	Yes (1)	No (2)	Don't Know (3)
1. Child abuse	☐	☐	☐
2. Child neglect	☐	☐	☐
3. Domestic violence	☐	☐	☐
4. Drug abuse	☐	☐	☐
5. Alcohol abuse	☐	☐	☐

16. In your professional judgement, to what extent, if at all, did the health of the foster caregiver(s) interfere with the ability to parent? (CHECK ONE FOR EACH)

Caregiver 1

1. ☐ To a very great extent
2. ☐ To a great extent
3. ☐ To a moderate extent
4. ☐ To some extent
5. ☐ To little or no extent

Caregiver 2

1. ☐ To a very great extent
2 ☐ To a great extent
3. ☐ To a moderate extent
4. ☐ To some extent
5. ☐ To little or no extent
6. ☐ N/A, there was only one foster caregiver

SKILLS AND ABILITIES OF FOSTER CAREGIVER(S)

17. Is this child up-to-date with respect to each of the following health services? (CHECK ONE FOR EACH)

	Yes (1)	No (2)	Don't Know (3)	N/A (4)
1. Routine physical exam or well baby check-up	☐	☐	☐	☐
2. Immunizations	☐	☐	☐	☐
3 Dental check-ups	☐	☐	☐	☐
4. Vision check-ups	☐	☐	☐	☐

18. In your professional judgement, how adequately did the **primary** foster caregiver perform each of the following tasks?

(CHECK ONE FOR EACH)	Very adequately (1)	Adequately (2)	As adequately as not (3)	Inadequately (4)	Very inadequately (5)	N/A, child not of school age (6)
1. Provide supervision						
2. Set limits						
3. Enforce limits						
4. Provide emotional support						
5. Provide clothing						
6. Provide nutrition						
7. Provide a good role model						
8. Accept child into family						
9. Ensure school attendance						
10. Navigate foster care system						
11. Cooperate with courts and other players in foster care system						

19. In your professional judgement, how willing was the **primary** foster caregiver to perform each of the following?

(CHECK ONE FOR EACH)	Very Willing (1)	Willing (2)	As willing as unwilling (3)	Unwilling (4)	Very unwilling (5)
Child's Physical Health Needs					
1. To accept opinions of professionals, such as caseworkers or physicians, regarding the child's need for medical services					
2. To act on medical referrals for the child from professionals					
Child's Mental Health Needs					
3. To accept opinions of professionals, such as caseworkers or psychologists, regarding the child's need for mental health services					
4. To act on mental health referrals for the child from professionals					
Child's Educational Needs					
5. To accept opinions of professionals, such as caseworkers or teachers, regarding the child's need for educational services					
6. To act on educational referrals for the child from professionals					

20. Had at least one of the foster caregivers completed orientation or training to prepare him/her to be a foster parent?

    1. ☐ Yes (GO TO QUESTION 23)
    2. ☐ No (CONTINUE)

21. To what extent, if at all, did the lack of foster care orientation or training interfere with the ability of the foster caregiver(s) to navigate the foster care system? (CHECK ONE)

    1. ☐ To a very great extent
    2. ☐ To a great extent
    3. ☐ To a moderate extent
    4. ☐ To some extent
    5. ☐ To little or no extent

22. To what extent, if at all, did the lack of foster care orientation or training interfere with the ability of the foster caregiver(s) to cooperate with caseworkers, courts, and other players in the foster care system? (CHECK ONE)

    1. ☐ To a very great extent
    2 ☐ To a great extent
    3. ☐ To a moderate extent
    4. ☐ To some extent
    5. ☐ To little or no extent

STATE OVERSIGHT OF FOSTER CARE PLACEMENT

23. On September 15, 1997 was this child residing in a licensed or approved foster care placement? (CHECK ONE FOR YOUR STATE)

    For California placements

    1. ☐ Licensed or certified
    2. ☐ Approved for kinship or relative care only

    For Illinois placements

    1. ☐ Licensed for non-relatives
    2. ☐ Licensed for relatives
    3. ☐ Approved for relatives

24. About how many times have you or another caseworker visited this child between March 15 and September 15, 1997. (ENTER NUMBER OF VISITS)

    _____ Visits

CONTACTS WITH CHILD'S FAMILY

25. During the placement that this child was in on September 15, 1997, was the **mother** allowed to visit or contact this child? (CHECK ONE)

    1. ☐ Yes, during some or all of this placement (CONTINUE)
    2. ☐ No (GO TO QUESTION 28)
    3 ☐ N/A, mother's whereabouts were unknown (GO TO QUESTION 29)
    4. ☐ N/A, mother was deceased (GO TO QUESTION 29)

26. During this placement did the **mother** visit or contact this child as often, more often, or less often than specified in the service plan? (CHECK ONE)

    1. ☐ Much more often than specified
    2. ☐ More often than specified
    3. ☐ As often as specified
    4. ☐ Less often than specified
    5. ☐ Much less often than specified
    6. ☐ N/A, visits were not specified in the plan

27. In your professional judgement, to what extent did the number and nature of visits or contacts that actually occurred allow the **mother** and child to have the relationship intended in the service plan? (CHECK ONE)

    1. ☐ To a very great extent
    2. ☐ To a great extent
    3. ☐ To a moderate extent
    4. ☐ To some extent
    5. ☐ To little or no extent

28. In your professional judgement, how likely was it that one or both of the foster caregivers would have taken the necessary actions to enforce visitation restrictions that may have applied to this child's **mother**? (CHECK ONE)

    1. ☐ Very likely
    2. ☐ Likely
    3. ☐ As likely as unlikely
    4. ☐ Unlikely
    5. ☐ Very unlikely
    6. ☐ N/A, visits were not restricted

29. During the placement that this child was in on September 15, 1997, was the **father** allowed to visit or contact this child? (CHECK ONE)

    1. ☐ Yes, during some or all of this placement (CONTINUE)
    2. ☐ No (GO TO QUESTION 32)
    3 ☐ N/A, father's whereabouts were unknown (GO TO QUESTION 33)
    4. ☐ N/A, father was deceased (GO TO QUESTION 33)

30. During this placement did the **father** visit or contact this child as often, more often, or less often than specified in the service plan? (CHECK ONE)

    1. ☐ Much more often than specified
    2. ☐ More often than specified
    3. ☐ As often as specified
    4. ☐ Less often than specified
    5. ☐ Much less often than specified
    6. ☐ N/A, visits were not specified in the plan

31. In your professional judgement, to what extent did the number and nature of visits or contacts that actually occurred allow the **father** and child to have the relationship intended in the service plan? (CHECK ONE)

    1. ☐ To a very great extent
    2. ☐ To a great extent
    3. ☐ To a moderate extent
    4. ☐ To some extent
    5. ☐ To little or no extent

32. In your professional judgement, how likely was it that one or both of the foster caregivers would have taken the necessary actions to enforce visitation restrictions that may have applied to this child's **father**? (CHECK ONE)

    1. ☐ Very likely
    2. ☐ Likely
    3. ☐ As likely as unlikely
    4. ☐ Unlikely
    5. ☐ Very unlikely
    6. ☐ N/A, visits were not restricted

33. Does this child have siblings?

    1. ☐ Yes--> How many? _____siblings
    2. ☐ No (GO TO QUESTION 38)

34. As of September 15, 1997, did your state have custody of any of these siblings?

    1. ☐ Yes--> How many? _____siblings
    2. ☐ No (GO TO QUESTION 36)

35. How many of these siblings, who were also in protective custody, resided in the same placement as this child? (CHECK ONE)

    1. ☐ All (GO TO QUESTION 38)
    2. ☐ Some
    3. ☐ None

36. Which of the situations below best describes the degree to which the visits or contacts between siblings met the service plan's specifications? (CHECK ONE)

    1. ☐ All the siblings visited or contacted this child at least as often as specified
    2. ☐ At least one but not all of the siblings visited or contacted this child as often as specified
    3. ☐ At least one of the siblings visited or contacted this child, but not as often as specified
    4. ☐ None of the siblings ever visited or contacted this child
    5. ☐ N/A, no visits were allowed by any siblings (GO TO QUESTION 38)
    6. ☐ N/A, visits were not specified in the plan (GO TO QUESTION 38)

37. In your professional judgement, to what extent did the number and nature of visits that actually occurred allow the sibling(s) and child to have the relationship intended in the service plan? (CHECK ONE)

    1. ☐ To a very great extent
    2. ☐ To a great extent
    3. ☐ To a moderate extent
    4. ☐ To some extent
    5. ☐ To little or no extent

38. Did this child maintain contact with relatives other than relative foster caregivers, siblings and parents? (CHECK ONE)

    1. ☐ Yes, maintained contact with at least one other relative
    2. ☐ No, child had little or no contact with other relatives
    3. ☐ N/A, child had no other known relatives

CONTACTS WITH CHILD'S PRIOR ENVIRONMENT

39. With about how many of the friends this child had just prior to this foster care episode did this child visit or otherwise communicate during this placement? (CHECK ONE)

1. ☐ All or almost all
2. ☐ Some
3. ☐ Few, if any
4. ☐ Don't know
5. ☐ N/A, child was too young to have friends or had no friends

40. Is the school in which this child was enrolled on September 15, 1997, the same school as the one he/she would have attended if he/she had not entered this episode of foster care? (CHECK ONE)

1. ☐ Yes
2. ☐ No
3. ☐ Don't know
4. ☐ N/A, child was not enrolled in school
   --> Why? (CHECK ONE)
   A. ☐ child too young
   B. ☐ child dropped out of school
   C. ☐ child graduated
   D. ☐ other (PLEASE SPECIFY)

_____

41. Did this child regularly attend one place of worship just prior to this foster care episode? (CHECK ONE)

1. ☐ Yes (CONTINUE)
2. ☐ No (GO TO QUESTION 43)
3. ☐ Don't know (GO TO QUESTION 43)

42. Did this child regularly attend the same place of worship during this placement? (CHECK ONE)

1. ☐ Yes
2. ☐ No
3. ☐ Don't know

43. Consider the neighborhood in which this child resided just prior to this foster care episode. Did this child reside in the same neighborhood on September 15, 1997? (CHECK ONE)

1. ☐ Yes
2. ☐ No
3. ☐ Don't know

PERMANENCY PLANNING STATUS

44. The Adoption Assistance and Child Welfare Act of 1980 (P.L. 96-272) requires that states conduct an initial permanency planning hearing within 18 months after a child enters foster care. At the initial permanency planning hearing, goals other than reunification (e.g., adoption, long term foster care, legal guardianship, independent living) begin to be considered. The goal may not necessarily be changed at that time.

As of September 15, 1997, had the initial permanency planning hearing been held for this child?

1. ☐ Yes--> On what date?

   _____
   Month / Day / Year
2. ☐ No

45. On September 15, 1997, what was the goal for this child? (CHECK ONE)

1. ☐ Reunification (GO TO QUESTION 50)
2. ☐ Adoption (GO TO QUESTION 57 ON PAGE 11)
3. ☐ Guardianship
4. ☐ Long term foster care
5. ☐ Independent living or emancipation
6. ☐ Other (PLEASE SPECIFY)

_____

PERMANENCY FOR CHILDREN WITH ANY PLAN OTHER THAN REUNIFICATION OR ADOPTION

46. As of September 15, 1997, for about how long had guardianship, long term foster care, or independent living/emancipation been this child's goal?

_____ years _____months

47. During this foster care episode, about how long had reunification been this child's goal?

_____ years _____months

A. ☐ N/A, reunification was never the goal

48. What is the **primary** reason adoption is not the permanency goal for this child? (CHECK ONE)

1. ☐ Child was old enough to be a party to the decision and did not want to be adopted
2. ☐ Although not old enough to be a party to the decision, this child's attitude toward adoption was so negative that it would have hindered a successful placement
3. ☐ Child has such severe special needs that adoption was unlikely
4. ☐ Financial assistance for adoption was not considered sufficient to meet this child's lifelong needs
5. ☐ Child was in kinship or relative care with foster caregiver(s) who did not want to adopt and removing this child from the placement was considered detrimental
6. ☐ A relative volunteered to become the foster caregiver to avoid having this child adopted by non-relatives
7. ☐ Adoption attempt was disrupted
8. ☐ Adoptive home could not be found (PLEASE SPECIFY WHY)

_____

9. ☐ Other (PLEASE SPECIFY)

_____

49. Has a guardian, other than the state or foster care agency, been appointed for this child by the court and if so what is the guardian's relationship to the child? (CHECK ONE)

1. ☐ Yes, a relative as defined by your state
2. ☐ Yes, a person (not a relative) this child knew before entering foster care
3. ☐ Yes, someone else
4. ☐ No

(WHEN YOU COMPLETE QUESTION 49, GO TO QUESTION 61 ON PAGE 11)

PERMANENCY FOR CHILDREN WITH A PLAN OF REUNIFICATION

50. As of September 15, 1997, about how long had reunification been this child's goal?

_____ years _____months

51. Consider the progress this child's mother made in meeting the requirements of the service plan. In your professional judgement, when is reunification likely to occur with the **mother**? (CHECK ONE)

1. ☐ Within 6 months
2. ☐ Within 7 to 12 months
3. ☐ Within 13 to 18 months
4. ☐ In more than 18 months
5. ☐ Unlikely to occur, regardless of time allowed
6. ☐ N/A, reunification with the mother was not in the service plan or her whereabouts were unknown (GO TO QUESTION 53)
7. ☐ N/A, mother was deceased (GO TO QUESTION 54)

52. In your professional judgement, what action in the service plan will be the most difficult for this child's **mother** to complete? (CHECK ONE)

1. ☐ Stop abusing substances and/or remain substance free
2. ☐ Visit this child
3. ☐ Overcome mental illness
4. ☐ Obtain counseling for other problems
5. ☐ Other (PLEASE SPECIFY)

_____

53. Has the court determined whether the state/child welfare agency has made reasonable efforts toward reunification with the **mother**? (CHECK ONE)

1. ☐ Yes, the court ruled that the state/child welfare agency has made reasonable efforts
2. ☐ Yes, the court ruled that the state/child welfare agency has **not** made reasonable efforts (PLEASE SPECIFY ACTION REQUIRED)

_____

3. ☐ No, the court has not ruled on the reasonableness of the state/child welfare agency reunification efforts

54. Consider the progress this child's father made in meeting the requirements of the service plan. In your professional judgement, when is reunification likely to occur with the **father**? (CHECK ONE)

1. ☐ Within 6 months
2. ☐ Within 7 to 12 months
3. ☐ Within 13 to 18 months
4. ☐ In more than 18 months
5. ☐ Unlikely to occur, regardless of time allowed
6. ☐ N/A, reunification with the father was not in the service plan or his whereabouts were unknown (GO TO QUESTION 56)
7. ☐ N/A, father was deceased (GO TO QUESTION 61)

55. In your professional judgement, what action in the service plan will be the most difficult for this child's **father** to complete? (CHECK ONE)

1. ☐ Stop abusing substances and/or remain substance free
2. ☐ Visit this child
3. ☐ Overcome mental illness
4. ☐ Obtain counseling for other problems
5. ☐ Other (PLEASE SPECIFY)

_____

56. Has the court determined whether the state/child welfare agency has made reasonable efforts toward reunification with the **father**? (CHECK ONE)

1. ☐ Yes, the court ruled that the state/child welfare agency has made reasonable efforts
2. ☐ Yes, the court ruled that the state/child welfare agency has **not** made reasonable efforts (PLEASE SPECIFY ACTION REQUIRED)

_____

3. ☐ No, the court has not ruled on the reasonableness of the state/child welfare agency reunification efforts

(WHEN YOU COMPLETE QUESTION 56, GO TO QUESTION 61)

PERMANENCY FOR CHILDREN WITH A PLAN OF ADOPTION

57. About how long has adoption been this child's goal?

_____ years _____months

58. In your professional judgement, how likely is it that this child will be adopted? (CHECK ONE)

1. ☐ Very likely
2. ☐ Likely
3. ☐ As likely as unlikely
4. ☐ Unlikely
5. ☐ Very unlikely

59. As of September 15, 1997, did this child reside in a pre-adoptive home?

1. ☐ Yes
2. ☐ No

60. During this foster care episode, about how long had reunification been this child's goal?

_____ years _____months

A. ☐ N/A, reunification was never the goal

HISTORY OF PARENTAL SUBSTANCE ABUSE AND RELATED CRIMINAL BEHAVIOR

This section of the questionnaire will be used to provide the Congress with information on an issue other than kinship care: the implications of parental substance abuse for reunification and other child welfare outcomes.

61. On September 15, 1997, about how old were the child's parents? (ENTER NUMBER OF YEARS)

Mother

_____ years of age

A. ☐ Don't know

Father

_____ years of age

A. ☐ Don't know

62. Consider all the service plans for this foster care episode. Was this child's **mother** required to undergo drug or alcohol treatment as part of a service plan? (CHECK ONE)

1. ☐ Yes (CONTINUE)
2. ☐ No (GO TO QUESTION 71 ON PAGE 13)
3. ☐ Don't know (GO TO QUESTION 71 ON PAGE 13)
4. ☐ N/A, mother was deceased or whereabouts were unknown (GO TO QUESTION 71 ON PAGE 13)

63. Which of the statements below best describes the **mother's** progress toward meeting this requirement? (CHECK ONE)

1. ☐ Successfully fulfilled the treatment requirement
2. ☐ Currently in treatment but not completed
3. ☐ Entered a program but failed to complete it
   --> Why? (CHECK ALL THAT APPLY)
   - A. ☐ Drug or alcohol relapse occurred
   - B. ☐ Medical condition interfered
   - C. ☐ Mental condition interfered
   - D. ☐ Incarcerated
   - E. ☐ Don't know
   - F. ☐ Other (PLEASE SPECIFY)

   _____
4. ☐ Currently on a waiting list--> How long on the waiting list?
   _____ months
5. ☐ No appropriate treatment program was accessible
6. ☐ Not sufficiently motivated to enter treatment
7. ☐ Other (PLEASE SPECIFY)

   _____

64. What substances was this child's **mother** abusing around the time this foster care episode began? (CHECK ONE FOR EACH)

	Yes (1)	No (2)	Don't Know (3)
1. Crack cocaine	☐	☐	☐
2. Powder cocaine	☐	☐	☐
3. Cocaine (type unknown)	☐	☐	☐
4. Heroin	☐	☐	☐
5. Other opiates or type of opiate unknown	☐	☐	☐
6. Methamphetamine	☐	☐	☐
7. Alcohol	☐	☐	☐
8. Other (PLEASE SPECIFY)	☐	☐	☐

_____

65. What was the drug of choice of this child's **mother** around the time this foster care episode began? (CHECK ONE)

1. ☐ Crack cocaine
2. ☐ Powder cocaine
3. ☐ Cocaine (type unknown)
4. ☐ Heroin
5. ☐ Other opiates or type of opiate unknown
6. ☐ Methamphetamine
7. ☐ Alcohol
8. ☐ Other (PLEASE SPECIFY)

_____

66. Based on your knowledge of the history of substance abuse by this child's **mother**, about how long ago did she initially begin abusing drugs or alcohol? (CHECK ONE)

1. ☐ Less than 1 year ago
2. ☐ 1 through 4 years ago
3. ☐ 5 through 9 years ago
4. ☐ 10 years ago or more
5. ☐ Don't know

67. Was this child's **mother** incarcerated at the time this foster care episode began? (CHECK ONE)

1. ☐ Yes
2. ☐ No
3. ☐ Don't know

68. Certain crimes are sometimes linked to substance abuse. Was this child's **mother** arrested or convicted of any the following crimes around the time this foster care episode began? (CHECK ONE FOR EACH)

	Yes (arrested only) (1)	Yes (convicted) (2)	No (3)	Don't know (4)
1. Under the influence of drugs or alcohol	☐	☐	☐	☐
2. Drug possession	☐	☐	☐	☐
3. Drug sales	☐	☐	☐	☐
4. Prostitution	☐	☐	☐	☐
5. Theft/burglary	☐	☐	☐	☐
6. Assault/rape	☐	☐	☐	☐
7. Homicide	☐	☐	☐	☐
8. Other (PLEASE SPECIFY)	☐	☐	☐	☐

_____

69. Was this child's **mother** subsequently arrested or convicted of any crimes during this foster care episode? (CHECK ONE FOR EACH)

	Yes (arrested only) (1)	Yes (convicted) (2)	No (3)	Don't know (4)
1. Under the influence of drugs or alcohol	☐	☐	☐	☐
2. Drug possession	☐	☐	☐	☐
3. Drug sales	☐	☐	☐	☐
4. Prostitution	☐	☐	☐	☐
5. Theft/burglary	☐	☐	☐	☐
6. Assault/rape	☐	☐	☐	☐
7. Homicide	☐	☐	☐	☐
8. Other (PLEASE SPECIFY)	☐	☐	☐	☐

_____

70. Has the **mother's** parental rights for this child been terminated, either by voluntary relinquishment or by court action?

1. ☐ Yes--> On what date? _____ Month / Day / Year
2. ☐ No

71. Consider all the service plans for this foster care episode. Was this child's **father** required to undergo drug or alcohol treatment as part of a service plan? (CHECK ONE)

1. ☐ Yes (CONTINUE)
2. ☐ No (GO TO QUESTION 80 ON PAGE 16)
3. ☐ Don't know (GO TO QUESTION 80 ON PAGE 16)
4. ☐ N/A, father was deceased or whereabouts were unknown (GO TO QUESTION 80 ON PAGE 16)

72. Which of the statements below best describes the **father's** progress toward meeting this requirement? (CHECK ONE)

1. ☐ Successfully fulfilled the treatment requirement
2. ☐ Currently in treatment but not completed
3. ☐ Entered a program but failed to complete it
   --> Why? (CHECK ALL THAT APPLY)
   A. ☐ Drug or alcohol relapse occurred
   B. ☐ Medical condition interfered
   C. ☐ Mental condition interfered
   D. ☐ Incarcerated
   E. ☐ Don't know
   F. ☐ Other (PLEASE SPECIFY)

   _____
4. ☐ Currently on a waiting list--> How long on the waiting list?
   _____ months
5. ☐ No appropriate treatment program was accessible
6. ☐ Not sufficiently motivated to enter treatment
7. ☐ Other (PLEASE SPECIFY)

   _____

73. What substances was this child's **father** abusing around the time this foster care episode began? (CHECK ONE FOR EACH)

	Yes (1)	No (2)	Don't Know (3)
1. Crack cocaine	☐	☐	☐
2. Powder cocaine	☐	☐	☐
3. Cocaine (type unknown)	☐	☐	☐
4. Heroin	☐	☐	☐
5. Other opiates or type of opiate unknown	☐	☐	☐
6. Methamphetamine	☐	☐	☐
7. Alcohol	☐	☐	☐
8. Other (PLEASE SPECIFY)	☐	☐	☐

_____

74. What was the drug of choice of this child's **father** around the time this foster care episode began? (CHECK ONE)

1. ☐ Crack cocaine
2. ☐ Powder cocaine
3. ☐ Cocaine (type unknown)
4. ☐ Heroin
5. ☐ Other opiates or type of opiate unknown
6. ☐ Methamphetamine
7. ☐ Alcohol
8. ☐ Other (PLEASE SPECIFY)

_____

75. Based on your knowledge of the history of substance abuse by this child's **father**, about how long ago did he initially begin abusing drugs or alcohol? (CHECK ONE)

1. ☐ Less than 1 year ago
2. ☐ 1 through 4 years ago
3. ☐ 5 through 9 years ago
4. ☐ 10 years ago or more
5. ☐ Don't know

76. Was this child's **father** incarcerated at the time this foster care episode began? (CHECK ONE)

1. ☐ Yes
2. ☐ No
3. ☐ Don't know

77. Certain crimes are sometimes linked to substance abuse. Was this child's **father** arrested or convicted of any of the following crimes around the time this foster care episode began? (CHECK ONE FOR EACH)

	Yes (arrested only) (1)	Yes (convicted) (2)	No (3)	Don't know (4)
1. Under the influence of drugs or alcohol	☐	☐	☐	☐
2. Drug possession	☐	☐	☐	☐
3. Drug sales	☐	☐	☐	☐
4. Prostitution	☐	☐	☐	☐
5. Theft/burglary	☐	☐	☐	☐
6. Assault/rape	☐	☐	☐	☐
7. Homicide	☐	☐	☐	☐
8. Other (PLEASE SPECIFY) _____	☐	☐	☐	☐

78. Was this child's **father** subsequently arrested or convicted of any crimes during this foster care episode? (CHECK ONE FOR EACH)

	Yes (arrested only) (1)	Yes (convicted) (2)	No (3)	Don't know (4)
1. Under the influence of drugs or alcohol	☐	☐	☐	☐
2. Drug possession	☐	☐	☐	☐
3. Drug sales	☐	☐	☐	☐
4. Prostitution	☐	☐	☐	☐
5. Theft/burglary	☐	☐	☐	☐
6. Assault/rape	☐	☐	☐	☐
7. Homicide	☐	☐	☐	☐
8. Other (PLEASE SPECIFY) _____	☐	☐	☐	☐

79. Has the **father's** parental rights for this child been terminated, either by voluntary relinquishment or by court action?

1. ☐ Yes--> On what date? _____ Month / Day / Year
2. ☐ No

COMMENTS

80. If you have any comments about issues covered in this questionnaire, please note them below.

Thank you for completing this questionnaire.

Please detach and destroy the front cover of this questionnaire--which contains identifying information about the foster child--before returning your responses.

Survey Results

This appendix displays the frequency distributions of caseworkers' responses to our survey questions concerning substance abuse among parents of foster children in California and Illinois. The percentage given for each response category constitutes our estimate of the proportion of that state's open foster care cases for which that response applied. For each item with a response rate lower than 70 percent, we note the percentage of cases for which there was either no response or the response was "don't know." The sampling errors for these percentage estimates vary; however, no sampling error for any estimate in this appendix exceeds plus or minus 10 percentage points. The sampling errors for the mean number of months that foster care cases had been open (cited in table III.5) do not exceed plus or minus 7 months. None of the sampling errors for the numbers of foster care cases (cited in table III.6) exceed plus or minus 5,010 cases. Because there were comparatively fewer fathers for whom information was available, no population estimates were made for most questions concerning a foster child's father. Most of the tables in this appendix that show responses to these questions present only the number of sample cases for which each response was given. Table III.9 is the only instance in this appendix in which we do not provide a population estimate with respect to mothers of foster children. The subgroup of mothers who entered a drug or alcohol treatment program but failed to complete it was too small to estimate the proportion of mothers in the population who did not complete treatment for specific reasons.

Table III.1: Foster Care Cases in Which a Parent Was Required to Undergo Treatment for Drug or Alcohol Abuse

	California (n = 227)	Illinois (n = 292)
One or both parents	65.2%	74.3%
Neither parent	17.2	15.4
Unknown	17.6	10.3

Table III.2: Foster Care Cases Involving Parental Substance Abuse in Which the Mother Only, the Father Only, and Both Parents Were Substance Abusers

	California (n = 148)	Illinois (n = 217)
Mother only	56.8%	59.9%
Father only	8.8	4.6
Both parents	34.5	35.5

Note: About 30 percent of the fathers and less than 4 percent of the mothers in each state were deceased or their whereabouts were unknown.

Table III.3: Foster Care Cases Involving Parental Substance Abuse and Criminal Activity by at Least One Parent

	California (n =142)	Illinois (n = 216)
Criminal activity involved	46.5%	35.2%
Criminal activity not involved or unknown	53.5	64.8

Table III.4: Mothers With Children in Foster Care for at Least 1 Year, by Level of Progress in Drug or Alcohol Treatment

	California (n = 116)	Illinois (n = 173)
Successfully completed treatment	7.8%	11.0%
Currently in treatment	5.2	8.1
Failed to complete treatment	40.5	42.2
Never entered treatment	40.5	34.1
Other	6.0	4.6

Table III.5: Average Number of Months Children Spent in Foster Care Among Cases Involving Parental Substance Abuse in Which Family Reunification Was No Longer the Goal

	California (n = 122)	Illinois (n=187)
Months in foster care	66.0	50.1

Table III.6: Estimated Number of Cases of Children in Foster Care at Least 17 Months and Number Known to Involve Parental Substance Abuse

	California	Illinois
Parental substance abuse was involved	38,863	31,885
Parental substance abuse was not involved or it was not known whether it was involved	22,860	11,184
Total	**61,723**	**43,069**

Table III.7: Mothers Required to Undergo Drug or Alcohol Treatment as Part of a Service Plan

	California (n = 227)	Illinois (n = 292)
Required to undergo treatment	59.5%	70.9%
Not required to undergo treatment	18.9	17.5
Don't know/missing	11.0	6.2
Not available (mother was deceased or whereabouts unknown)	10.6	5.5

Table III.8: Mother's Progress Toward Meeting the Requirement to Undergo Drug or Alcohol Treatment

	California (n = 123)	Illinois (n = 188)
Successfully fulfilled the treatment requirement	8.1%	10.6%
Currently in treatment but not completed	5.7	9.6
Entered a program but failed to complete it	40.7	39.9
Currently on a waiting list	0.0	0.0
No appropriate treatment program was accessible	0.0	0.5
Not sufficiently motivated to enter treatment	39.8	34.6
Other	5.7	4.8

Table III.9: Reasons the Mother Failed to Complete a Drug or Alcohol Treatment Program

	California (n = 41)	Illinois (n = 65)
Drug or alcohol relapse occurred	25	47
Medical condition interfered	3	6
Mental condition interfered	11	10
Incarcerated	10	14
Uncooperative in treatment program	3	10
Whereabouts became unknown	0	2
Other	5	13

Note: These data are based on a "check all that apply" question.

Table III.10: Substances Abused by the Mother Around the Time This Foster Care Episode Began

	California (n = 106)	Illinois (n = 187)
Crack-cocaine	34.9%	33.7%
Powder cocaine	6.6	11.2
Cocaine (type unknown)	29.2	50.3
Heroin	15.1	16.0
Other opiates or type of opiate unknown	9.4	8.0
Methamphetamine	34.9	2.1
Alcohol	50.9	48.1
Marijuana	7.5	9.1
Methadone	0.0	1.1
Other	8.5	3.2

Note: These data are based on a "check all that apply" question.

Table III.11: Mother's Drug of Choice Around the Time This Foster Care Episode Began

	California (n = 78)	Illinois (n = 155)
Crack-cocaine	28.2%	25.8%
Powder cocaine	0.0	2.6
Cocaine (type unknown)	23.1	41.9
Heroin	6.4	9.7
Other opiates or type of opiate unknown	1.3	0.6
Methamphetamine	26.9	0.6
Alcohol	11.5	14.2
Marijuana	0.0	3.9
Other	2.6	0.6

Notes: Due to rounding during the estimation process, percentages do not total 100. Information about the drug of choice for mothers was missing in about 42 percent of the cases in California and 25 percent of the cases in Illinois.

Table III.12: Number of Years Since the Mother Initially Began Abusing Drugs or Alcohol

	California (n = 90)	Illinois (n = 140)
Less than 1 year	2.2%	0.7%
1 through 4 years	15.6	17.1
5 through 9 years	18.9	41.4
10 years or more	63.3	40.7

Note: Data on the length of time that mothers abused drugs or alcohol was missing in about one-third of the cases in each state.

Table III.13: Mothers Incarcerated at the Time This Foster Care Episode Began

	California (n = 102)	Illinois (n = 185)
Mother incarcerated	17.6%	4.3%
Mother not incarcerated	82.3	95.7

Table III.14: Types of Crimes Mothers Were Arrested or Convicted for Around the Time This Foster Care Episode Began

	California (n = 124)		Illinois (n = 200)	
	Arrested only	Convicted	Arrested only	Convicted
Under the influence of drugs or alcohol	12.1%	6.5%	2.5%	1.0%
Drug possession	11.3	8.9	6.5	5.0
Drug sales	6.5	1.6	1.5	2.0
Prostitution	6.5	3.2	5.5	0.5
Theft/burglary	4.8	8.1	5.5	3.0
Assault/rape	1.6	0.8	1.0	1.5
Homicide	0.0	0.0	0.0	0.5
Other	1.6	1.6	3.0	3.5

Note: These data are based on a "check all that apply" question.

Table III.15: Types of Crimes Mothers Were Arrested or Convicted for Subsequent to the Beginning of This Foster Care Episode

	California (n = 125)		Illinois (n = 203)	
	Arrested only	Convicted	Arrested only	Convicted
Under the influence of drugs or alcohol	8.8%	6.4%	2.5%	1.0%
Drug possession	6.4	8.8	4.9	4.4
Drug sales	5.6	0.8	2.0	2.5
Prostitution	4.8	2.4	2.5	0.5
Theft/burglary	4.0	6.4	3.0	3.9
Assault/rape	2.4	0.8	0.0	2.0
Homicide	0.0	0.0	0.0	0.0
Other	1.6	0.8	3.0	4.4

Note: These data are based on a "check all that apply" question.

Table III.16: Mothers Whose Parental Rights Had Been Terminated, Either Voluntarily or by Court Action

	California (n = 130)	Illinois (n = 206)
Parental rights terminated	17.7%	24.8%
Parental rights not terminated	82.3	75.2

Table III.17: Fathers Required to Undergo Drug or Alcohol Treatment as Part of a Service Plan

	California (n = 227)	Illinois (n = 292)
Required to undergo treatment	28.2%	29.8%
Not required to undergo treatment	20.7	24.0
Don't know/missing	15.4	9.2
Not available (father was deceased or whereabouts unknown)	35.7	37.0

Table III.18: Father's Progress Toward Meeting the Requirement to Undergo Drug or Alcohol Treatment

	California (n = 60)	Illinois (n = 80)
Successfully fulfilled the treatment requirement	4	4
Currently in treatment but not completed	2	3
Entered a program but failed to complete it	17	15
Currently on a waiting list	0	1
No appropriate treatment program was accessible	1	0
Not sufficiently motivated to enter treatment	33	46
Other	3	11

Table III.19: Reasons the Father Failed to Complete a Drug or Alcohol Treatment Program

	California (n = 14)	Illinois (n = 13)
Drug or alcohol relapse occurred	8	8
Medical condition interfered	2	0
Mental condition interfered	1	1
Incarcerated	7	4
Uncooperative in treatment program	0	1
Whereabouts became unknown	0	0
Other	1	1

Note: These data are based on a "check all that apply" question.

Table III.20: Substances Abused by the Father Around the Time This Foster Care Episode Began

	California (n = 49)	Illinois (n = 48)
Crack-cocaine	9	9
Powder cocaine	4	1
Cocaine (type unknown)	11	21
Heroin	8	4
Other opiates or type of opiate unknown	1	2
Methamphetamine	16	1
Alcohol	32	30
Marijuana	6	3
Methadone	0	0
Other	0	0

Notes: These data are based on a "check all that apply" question. Data were missing in about 23 percent of the cases in California and 45 percent of the cases in Illinois.

Table III.21: Father's Drug of Choice Around the Time This Foster Care Episode Began

	California (n = 32)	Illinois (n = 38)
Crack-cocaine	3	3
Powder cocaine	0	0
Cocaine (type unknown)	7	15
Heroin	3	2
Other opiates or type of opiate unknown	1	1
Methamphetamine	10	0
Alcohol	8	16
Marijuana	0	1
Other	0	0

Note: Data were missing in about 50 percent of the cases in California and 56 percent of the cases in Illinois.

Table III.22: Number of Years Since the Father Initially Began Abusing Drugs or Alcohol

	California (n = 34)	Illinois (n = 29)
Less than 1 year	0	0
1 through 4 years	3	3
5 through 9 years	9	9
10 years or more	22	17

Note: Data were missing in about 47 percent of the cases in California and 67 percent of the cases in Illinois.

Table III.23: Number of Fathers Incarcerated at the Time This Foster Care Episode Began

	California (n = 44)	Illinois (n = 49)
Father incarcerated	21	16
Father not incarcerated	23	33

Note: Data were missing in about 31 percent of the cases in California and 44 percent of the cases in Illinois.

Table III.24: Types of Crimes Fathers Were Arrested or Convicted for Around the Time This Foster Care Episode Began

	California (n = 60)		Illinois (n = 84)	
	Arrested only	Convicted	Arrested only	Convicted
Under the influence of drugs or alcohol	5	10	2	2
Drug possession	5	12	5	9
Drug sales	2	4	3	7
Prostitution	1	0	0	0
Theft/burglary	4	7	3	7
Assault/rape	3	1	4	2
Homicide	0	0	0	2
Other	3	3	4	2

Note: These data are based on a “check all that apply” question.

Table III.25: Types of Crimes Fathers Were Arrested or Convicted for Subsequent to the Beginning of This Foster Care Episode

	California (n = 60)		Illinois (n = 82)	
	Arrested only	Convicted	Arrested only	Convicted
Under the influence of drugs or alcohol	3	6	2	0
Drug possession	3	7	2	6
Drug sales	3	3	2	3
Prostitution	1	0	0	0
Theft/burglary	1	4	4	4
Assault/rape	4	0	3	2
Homicide	0	0	0	2
Other	6	3	1	2

Note: These data are based on a “check all that apply” question.

Table III.26: Number of Fathers Whose Parental Rights Had Been Terminated, Either Voluntarily or by Court Action

	California (n = 64)	Illinois (n = 85)
Parental rights terminated	16	23
Parental rights not terminated	48	62

Description of Selected Foster Care Cases by Case Outcome

Family Reunification

Case 1 involved the youngest of four children. He, and one of his siblings, had been prenatally exposed to cocaine. As a result of neglect related to his mother's cocaine abuse, he entered foster care at birth. He and all three of his siblings, who were also in foster care, were placed with their maternal grandmother. When he was removed from his mother's custody, she lacked a stable residency, was unemployed, and had been convicted for felony drug possession and prostitution. His father's whereabouts were unknown at the time. His father had not been located by the time this child returned to his mother's care, but it was learned that he also had been convicted of felony drug possession and sales. Despite the mother's long history of drug use and related criminal activity, she met all of the case plan requirements to be reunified with this child. She completed about 1 year of drug treatment, including residential and outpatient programs, and participated in follow-up drug treatment support groups. She visited this child as prescribed in the plan, attended parenting classes, and obtained suitable housing. This child was returned to the mother's custody on a trial basis about 18 months after he entered foster care. At that point, she had tested "clean" in random drug tests for over 6 months. He remained with his mother for about 1 year on a trial basis during which time family maintenance services were provided. About 2-1/2 years after this child entered foster care, his mother was granted permanent custody, and this case was closed.

Case 2 involved the third oldest of five children. He entered foster care when he was 6 years old after his mother gave birth to her youngest, and third prenatally cocaine-exposed, child. As a result of neglect and risk of physical injury related to the mother's cocaine abuse, he and his four siblings were removed from their mother's custody and placed with their maternal grandmother. This mother had a 14-year history of substance abuse and had previously come to the attention of the child welfare agency in the mid-1980s for medical neglect of one of her older children. She was unemployed, and the father was incarcerated at the time the children were placed in foster care. Despite the complicating family situation, the mother met all of the case plan requirements to be reunified with this child. She spent about 1 month in a women's residential treatment program and another month in an outpatient program and participated in follow-up drug treatment support groups. She visited this child as prescribed in the plan, attended parenting classes and counseling sessions, and obtained suitable housing. This child was returned to his mother on a trial basis about 16 months after he entered foster care. He remained with his mother for 5 months on a trial basis. About 21 months

after the child entered foster care, his mother was granted permanent custody, and this case was closed.

Case 3 involved the middle child of three. She was 9 years old when all three siblings were placed in foster care as a result of neglect related to the mother's alcohol abuse. Her parents failed to keep hospital appointments for her 2-year-old brother, who was born premature (weighing only a little more than 3 pounds) and had been diagnosed as a "failure to thrive" infant with fetal alcohol syndrome (FAS) and developmental delays. Also, a home health aide, who had been visiting the home since the younger brother's birth, reported that this girl and her older brother were not being fed regularly. The younger brother was placed in a specialized family foster home for the developmentally delayed, and this girl and her older brother were placed with a foster family. The mother had a 15-year history of alcohol abuse and was mildly mentally retarded. In addition, the caseworker suspected that the father verbally abused the mother. The mother met many of the case plan requirements despite the complicated family situation. For 9 months, she participated in an outpatient treatment program for her alcohol abuse problem, and she continued her treatment through follow-up support groups. She also tested clean in random alcohol tests. Although initially resistant, the mother began cooperating with home visits to assess her housekeeping skills and the safety of the home. Both of this girl's parents also participated in parenting classes. However, they initially visited their children only irregularly, and neither parent demonstrated any affection toward the younger brother during these scheduled visits. Her parents relinquished their parental rights of the younger brother who remained in the specialized family foster home where he was initially placed. However, after spending about 16 months in foster care, this girl and her older brother were reunified with their parents.

Adoption

Case 4 involved the older of two children. She was 1-1/2 years old when she entered foster care, following the birth of her sibling who had been prenatally exposed to cocaine, opiates, and methamphetamines. She was placed in the care of her maternal grandmother. Her younger sibling, who had a different father, was also placed in foster care but not with the maternal grandmother—who said she was unable to take care of both children. The mother, who disappeared shortly after the birth of the second child, had a long history of abusing multiple substances; she had been abusing cocaine and heroin for almost a decade. She had a criminal record for felony drug possession, had been incarcerated several times,

and lacked a stable residency. The identity of the older child's father was unknown, and the mother claimed to have never known his identity. The mother refused to comply with any of the case plan requirements to be reunified with her children: she failed to enter a drug treatment program or submit to drug testing, and she visited her children only irregularly. It was not clear from the case file when the permanency goal was changed from family reunification to some other goal. Although the maternal grandmother said she could not assume custody of both children, she adopted this child at age 5 and received financial assistance under the title IV-E adoption assistance program. The younger sibling was adopted about the same time by the foster family with whom this child had been placed. When these adoptions were finalized, both she and her sibling had been in foster care for nearly 4 years.

Case 5 involved one of two siblings. Both she and her sibling had been prenatally exposed to cocaine and were placed in foster care as a result of neglect related to the mother's cocaine abuse. She was about 1 year old at the time of removal. Three older children by a different father were already in the informal care of relatives. This child was placed with two different foster families during the time she was in foster care. She was developmentally delayed, had vision problems, and was receiving counseling for emotional problems. Her mother abused both alcohol and cocaine, and her cocaine abuse dated back almost 20 years. Her father also had a substance abuse problem, although he claimed to have stopped abusing cocaine after his children were removed from the mother's custody and placed in foster care. This child and her sibling were the result of an affair he had with the mother, but he was unwilling to assume custody of the children because his wife did not want them living with her and her husband. Meanwhile, reunification services were offered to the mother. Although the mother completed 6 months of residential treatment, she relapsed, as she had several times before this foster care episode. She was dropped from another treatment program during this foster care episode for lack of attendance. She demonstrated a "pattern of manipulation and dishonesty" with caseworkers and was said to continue to deny the seriousness of her substance abuse problem. She also failed to comply with other requirements in her case plan. For example, she tested positive on some of the random drug tests and did not regularly visit this child. The permanency goal was changed from family reunification to adoption about 21 months after this child entered foster care. The child was adopted, when she was 4 years old, by the foster family with whom she was placed during most of her time in foster care. When the adoption was finalized, this child had been in foster care for more than 3 years.

Case 6 involved an infant who had been prenatally exposed to cocaine and had to be closely monitored because of serious medical complications. She was placed in foster care because of the mother's medical neglect. She weighed only about 2 pounds at birth, suffered from respiratory distress syndrome, had neurological abnormalities, and later developed cerebral palsy. Her mother, after being released from the hospital, visited the child infrequently and made no plans to provide for her special medical needs. The identity of the child's father was unknown at the time of birth. The child remained in the hospital for several months and was then placed with a foster family that was also certified to adopt. This mother had a very complicated family history. She had been in foster care herself in the custody of her own grandparents. Both of the mother's parents had criminal records and were currently incarcerated for drug convictions. A criminal records review of the mother identified several warrants and prior arrests. She had a history of abusing multiple substances and had previously given birth to a child with a different father and that child was currently in his care. She failed to complete any of the requirements in the case plan for family reunification, including beginning a drug and alcohol treatment program even though a slot was located for her by the caseworker. Within months of this child's entering foster care, the mother relinquished her parental rights. About the same time, the father came forward and relinquished his parental rights. The child's foster parents adopted the child and received financial assistance under the title IV-E adoption assistance program because of the special needs of this child. When the adoption was finalized, she was 3 years old and had been in foster care since birth.

Legal Guardianship

Case 7 involved a 1-year-old child. She was abandoned in a hospital where her mother, who appeared to be under the influence at the time, had taken her. She was placed in foster care as a result of abandonment and neglect related to her mother's cocaine and alcohol abuse. She was blind in one eye, a condition attributed to the mother's neglect. She was also developmentally delayed, had a compromised immune system, and had behavioral problems. This same child had been placed in foster care for a brief period of time prior to this episode while her mother was incarcerated on drug-related charges. During this foster care episode, which began with the abandonment in the hospital, she was placed with a foster family. Her mother was subsequently incarcerated again for 2 years. The mother's history of criminal convictions and incarcerations included a felony conviction for drug possession. She had two other children by different fathers; one was in the care of a relative, and the other was

already an adult. The whereabouts of this child's father were initially unknown, and when his whereabouts became known, he indicated that he did not want custody of her. The mother participated in a drug treatment program while in prison. However, she apparently relapsed after she was released from prison. Although she attended parenting classes, she rarely visited her daughter. About 15 months after this child entered foster care, the permanency goal of family reunification was changed to long-term foster care and, later, adoption. Her foster parents indicated a preference for assuming guardianship instead of adopting her because of the high costs associated with her medical needs. These foster parents assumed legal guardianship of this child when she was 4 years old. When the case was formally closed, this child had been in foster care for nearly 3 years.

Case 8 involved one of seven children. He was almost 1 year old at the time he was placed in foster care as a result of neglect related to the substance abuse problems of both parents. He had tested positive at birth for PCP (phencyclidine hydrochloride). Several of his siblings, some by a different father, had also been prenatally drug-exposed and had been diagnosed with developmental delays. This child and his siblings were placed with a paternal aunt of the two oldest siblings. His mother lacked a stable residency, and family members believed that she was a prostitute. Her substance abuse problems continued to escalate during this foster care episode to a point at which, according to a family member, she was reportedly using cocaine every day. His father was uninvolved and failed to maintain any contact with the child welfare agency. An assessment of the paternal aunt's home several years after he had been placed there found that the home was in "poor condition." This relative had been unemployed for several years and was reportedly under stress because of the drug-related problems of her adult siblings. Further, the child's oldest brother was experiencing behavioral and emotional problems in this placement that were serious enough to warrant placing him temporarily in a residential treatment center when he threatened to commit suicide. This older brother was later returned to the home of the paternal aunt. In the meantime, his mother failed to comply with any of the requirements for family reunification. Although records indicate that she entered several residential and outpatient treatment programs, she did not stay in any program for a sustained period of time. Her visits with the children were described by the paternal aunt as typically unannounced, disruptive, and upsetting to the children. The permanency goal of family reunification was changed about 18 months after this child first entered foster care. Although his permanency goal became adoption by the relative with whom he was placed, the relative assumed a special form of

guardianship—referred to as Delegated Relative Authority (DRA).[61] By then, he had been in foster care for 5 years, at which time the case was formally closed.

Case 9 involved the oldest of five children. She and her siblings were placed in foster care because of neglect related to the father's substance abuse problem and domestic violence between the mother and father. She was 8 years old at the time she was removed and, with her siblings, placed with her maternal grandmother. While she had some speech and behavioral problems, some of the other children had more serious problems. Two of her siblings were diagnosed with attention deficit disorder, and one sibling had been hospitalized because of post-traumatic stress disorder. Her father, who used both crack-cocaine and alcohol, physically and emotionally abused the mother, who was his common-law spouse. After the children entered foster care, he was incarcerated for several months for committing forgery. He was also only sporadically employed, and he lacked a stable residency. While her mother did not have a substance abuse problem, she had other problems associated with being a victim of domestic violence: she had been sexually abused by her own father and brother, and she suffered from depression. Although the mother entered a confidential program for victims of domestic violence and complied with the visitation requirements with her children, the father failed to complete any of the case plan requirements for family reunification. The father entered drug treatment programs numerous times over a period of several years but dropped out each time after very short time periods in treatment. He was terminated from one program because of his abusive behavior toward the common-law spouse and suspicions that he had stolen money. The case file indicated that he "harassed and intimidated" staff at the child welfare agency. It is unclear from the case file when the permanency goal was changed from family reunification to some other goal. However, the maternal grandmother assumed legal guardianship of this child when she was 13 years old. This child had spent nearly 5 years in foster care when this case was formally closed.

Still in Foster Care

Case 10 involved one of six children. He and most of his siblings were known to have been prenatally exposed to cocaine. As a result of neglect related to his mother's crack-cocaine and alcohol abuse, he entered foster

[61]DRA as a permanency option is being phased out because the state was recently granted a waiver to grant subsidized guardianships. Under DRA, the relative caring for the foster child continued to receive payments based on the relative's licensing status. While the agency actually retained guardianship of the child, this form of placement allowed the child to remain in a stable living arrangement with much less involvement or monitoring of the placement by the agency.

care shortly after birth. Two of his siblings—one older and one younger—reportedly died of sudden infant death syndrome (SIDS). His mother had repeatedly left her children with unrelated adults for the night after telling them she would return in only a few minutes, which contributed to the decision to remove all of her children. This child was placed briefly with two different foster families, and then several months later he was placed with his maternal great aunt and uncle. His mother had a sporadic employment history and a criminal record for felony theft and misdemeanor drug possession. In addition, she had been incarcerated for probation violations. The identity of the father was unknown. His mother successfully complied with most of the requirements in the case plan for reunification—including visitation, a parenting class, and family therapy. However, about 2 years after this child entered foster care, his mother was dropped from a drug treatment program for lack of attendance. About that time, the permanency goal was changed from family reunification to long-term foster care. Over the next few years, she entered treatment several additional times but failed to complete each of these programs. About 3 months prior to the birth of his youngest sibling, she entered a 12-month residential drug treatment program, and this time she successfully completed the program. Because of her success in treatment, he was returned to the mother for several trial visits after spending about 7 years in foster care. However, his mother subsequently failed several drug tests, indicating that she had relapsed. He was returned to foster care with the relatives with whom he had previously been placed, where he remains in foster care almost 8 years after he entered.

Case 11 involved one of four children. One of her younger siblings had been prenatally exposed to cocaine and had been delivered by emergency cesarean section after her mother had been beat up by drug dealers for allegedly stealing drugs. Her removal from her mother's custody was ultimately triggered, when she was 6 years old, by the mother leaving her and her two siblings in the home of the mother's substance-abusing brother while she went out to sell diapers, cigarettes, tokens, and food stamps to buy cocaine. Another child of this mother had previously died of SIDS. This child was initially placed with a foster family and then in the home of her aunt. The placement with her aunt lasted about 1 year before it was terminated at the aunt's request because of the child's behavioral problems. She was later placed with another foster family. She not only had behavioral problems but was also developmentally delayed. She also had emotional problems associated with separation issues and prior sexual abuse, allegedly by her father. One of her other siblings also had behavioral and emotional problems and was a chronic runaway. When this

foster care episode began, the mother had been abusing both cocaine and marijuana for more than a decade. In addition to being absent at the time the children were removed, she was periodically absent throughout the foster care episode. The father, who had never been married to the mother, also had a substance abuse problem. He had a criminal record for carrying a concealed firearm and had been arrested on a number of different charges. While the mother entered drug treatment a number of times during this foster care episode, it is unclear whether she completed any of these programs. Her behavior, as described in the case file, suggests she was manipulative, having "learned many ways to cover up her continued abuse of drugs." The father had never entered any treatment program, and the only drug test performed on him revealed that he was still using. Two years and 4 months after this child entered foster care, the permanency goal was changed from family reunification to long-term foster care. At 10 years of age, she remains in foster care, over 4 years after she entered.

Case 12 involved the older of two children. He and his brother entered foster care when he was 3 years old after being abandoned by their substance-abusing mother. His mother left the house, reportedly to escape beatings by the father of his younger brother, and the two children were later discovered by a friend of the mother's. He had numerous physical problems associated with his prenatal exposure to cocaine, and emotional problems associated with severe physical and sexual abuse, allegedly by the younger brother's father. He was diagnosed with post-traumatic stress disorder in response to witnessing his mother being beaten. Both brothers also had developmental disabilities, including a diagnosis of attention deficit disorder. They were placed together with a foster family. His mother, in addition to her history of abusing crack-cocaine and alcohol abuse, had a criminal record and had been incarcerated for selling controlled substances. Moreover, she was diagnosed with serious mental illness, including schizophrenia and depression, and had been hospitalized several times since the foster care episode began for attempting suicide. The father of this older child was interested in assuming custody of the child but had a history of alcohol abuse and sporadic employment. He also failed to comply with any of the requirements in the case plan for family reunification. The mother participated in several different drug treatment programs, but her psychiatric problems and multiple admissions to hospitals for suicide attempts interfered with progress in drug treatment. In addition, the caseworker reported difficulties in finding facilities that could treat her dual diagnosis of mental health and substance abuse problems. She was also inconsistent in taking medications for her

psychiatric problems. About 19 months after he entered foster care, the foster care agency began to explore whether the maternal grandmother could assume custody should the mother continue to fail to make progress in meeting case plan requirements. However, the grandmother was later found to be an unsuitable placement, and the permanency goal became adoption almost 3 years after this child entered foster care. This child remains with his brother in the care of the same foster family with whom they were initially placed. At 6 years of age, he is still in foster care, over 3 years since he entered.

Aged Out

Case 13 involved the oldest of three children. At age 14, she and her two sisters entered foster care because of neglect related to the mother's abuse of cocaine, marijuana, and alcohol. Her mother left all three children with a friend after the family was evicted from their apartment. They had not seen their mother for about 2 weeks when the friend contacted the foster care agency. She was initially placed with a foster family, whereas her two younger sisters were placed with their mother in a residential drug treatment program. Prior to this foster care episode, one of her younger sisters had been in foster care after having been physically and sexually abused while informally in the care of a relative, but her sister was subsequently reunified with her family. In addition to the mother's prior involvement with the child welfare system, she had psychiatric problems and a prior conviction for intent to distribute marijuana, and she was also homeless. The father of these children also lacked a stable residency and had no interest in assuming custody of the children. After completing 2 months of residential treatment, the mother was provided transitional housing for an additional 2 months. However, she soon began to miss appointments for treatment as prescribed by her after-care program, and 6 months after her children were removed from her custody, her whereabouts became unknown. The caseworker believed that she was using drugs again. Meanwhile, this child was experiencing serious emotional and behavioral problems. She had been separated from her sisters, who were now with another foster family, since the beginning of the foster care episode. On at least four different occasions, she was admitted to hospitals for psychiatric problems, including attempted suicide. She was placed with four different foster families, and at least two of these placements were disrupted because of her emotional and behavioral problems. She was also briefly returned to her mother when she was nearly 15 years old, only to re-enter foster care a few months later at her mother's request. The mother told the agency she could not adequately care for her, and the mother claimed to have become suicidal.

Two years and 4 months after this child entered foster care, the permanency goal was changed from family reunification to long-term foster care. Her final placement was with foster parents who could meet her special needs. When she reached age 18, she had been in foster care almost 4 years. She continued to receive services through the title IV-E independent living program for several months until this case was formally closed.[62]

Case 14 involved one of three children. At 7 years of age she and her two siblings were placed in foster care because of neglect related to their mother's abuse of alcohol and PCP. The children were left at home alone without electricity or sufficient food. She was placed with her maternal grandmother. Placement information on her two siblings was not available. She and her siblings had no major health or behavioral problems other than asthma. Her mother, who lacked a stable residency and regular employment, failed to have any contact with the agency over the many years her children were in foster care. Consequently, there was little information in the case file about her problems. Although her father did not have a substance abuse problem, he said he was already caring for his parents with whom he lived and, because they had health problems, he was not interested in assuming custody of her. About 15 months after she entered foster care, the permanency goal became long-term foster care because the grandmother with whom she was placed for the duration of the foster care episode refused to assume legal guardianship. She did well academically and participated in extracurricular activities throughout high school. When she reached age 18, she had been in foster care for almost 11 years. Title IV-E independent living services were provided to this child for several additional years because of some academic difficulties she experienced while attending college.

Case 15 involved the older of two sisters. At age 15, she and her sister were placed in foster care because of physical abuse related to the mother's abuse of crack-cocaine. Her mother reportedly pointed a gun at her two daughters and threatened to kill them and herself. This child had marks on her body from physical abuse she had suffered at the hands of her mother; she also suffered from chronic headaches. She and her sister were placed together in the home of the maternal grandmother. The mother had a long history of substance abuse and chronic health problems associated with her overdosing on LSD (lysergic acid diethylamide) several times as a teenager. She was unemployed and had been convicted for

[62]The title IV-E independent living program offers services to assist children in the transition from foster care to self-sufficiency.

possessing an unregistered firearm. The father, who lived in another state at the time this child and her sister were removed, was not interested in assuming custody of them. His whereabouts later became unknown to the agency. The mother initially participated in an outpatient drug treatment program, maintained adequate housing, and obtained employment. However, she dropped out of the treatment program within the first year her children were in foster care because she said the program interfered with her work schedule. Although she participated in a follow-up drug treatment support program after she dropped out of outpatient treatment, she allegedly began using drugs again. About 18 months after this child entered foster care, the permanency goal changed from family reunification to independence. She remained with her maternal grandmother a little over 2 years, then moved, at age 18, into her own apartment while attending college. She reportedly was considering applying to law school and was preparing for the test that is required for admission. She continued to receive title IV-E independent living services until she turned 21 years of age.

Summary of State Termination of Parental Rights Laws Related to Parental Substance Abuse

Thirty states and the District of Columbia have foster care laws that specify that parental substance abuse is either a consideration in or grounds for terminating parental rights.[63] These states are Alabama, Arizona, California, Colorado, Georgia, Hawaii, Illinois, Iowa, Kansas, Louisiana, Maine, Massachusetts, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New York, North Carolina, Ohio, Oregon, Rhode Island, South Carolina, Tennessee, Texas, Utah, Virginia, Washington, and West Virginia.

Some state laws on terminating parental rights include more detailed provisions regarding permanency decisionmaking for foster care cases involving parental substance abuse. Other state laws include provisions that, while not specifically addressing the issue of parental substance abuse, are also relevant for decisionmaking in these cases. The following are examples of various state laws.

Arizona

Arizona law allows the termination of parental rights when a child has been in an out-of-home placement for a cumulative total of 9 months pursuant to a court order and the parent has substantially neglected or willfully refused to remedy the circumstances which caused the child to be in an out-of-home placement, or, at 18 months, if the parent has been unable to remedy the circumstances which caused the child to be in an out-of-home placement and there is substantial likelihood that the parent will not be capable of exercising proper and effective parental care and control in the near future. Ariz. Rev. Stat. §8-533B.7(a),(b).

California

California law does not require the foster care agency to provide a period of family reunification efforts before beginning proceedings to terminate parental rights if the parent has a history of extensive, abusive, and chronic use of drugs or alcohol and has resisted prior treatment during a 3-year period immediately prior to the filing of the petition that brought the minor to the court's attention or has failed or refused to comply with a program of drug or alcohol treatment described in the case plan on at least two prior occasions, even though the programs identified were available and accessible. Cal. Welf. & Inst. Code §361.5(b)(12).

Illinois

Illinois law does not require the foster care agency to provide a period of family reunification efforts before beginning proceedings to terminate

[63]Under these laws, judges retain discretion not to terminate parental rights.

parental rights if the foster child was prenatally substance-exposed and (1) the mother had prenatally substance-exposed at least one other child who was legally determined to have been neglected and (2) the mother had the opportunity to participate in a drug counseling, treatment, and rehabilitation program during that child's foster care episode. Parental rights may also be terminated if the parent has failed to make reasonable efforts to correct the conditions that were the basis for the removal of the child from the parent or to make reasonable progress toward the return of the child to the parent within 9 months after the child was legally determined to have been neglected. Failure to make reasonable progress toward return of the child includes the parent's failure to substantially fulfill his or her obligations under the service plan and correct the conditions that brought the child into foster care within 9 months after adjudication. 750 Ill. Comp. Stat. 50/1(1)(m),(r).

Louisiana

Louisiana law allows the termination of parental rights if (1) at least 1 year has elapsed since the foster child was removed from the parent's custody; (2) there has been no substantial parental compliance with a case plan for services necessary for the safe return of the child; and (3) despite earlier intervention, there is no reasonable expectation of significant improvement in the parent's condition or conduct in the near future, considering the child's age and needs for a stable and permanent home. La. Ch. Code art. 1015(5). Lack of parental compliance with a case plan includes the parent's repeated failure to comply with the required program of treatment and rehabilitation services provided in the case plan, the lack of substantial improvement in redressing the problems preventing reunification, and the persistence of conditions that led to removal or similar potentially harmful conditions. La. Ch. Code art. 1036C(5)-(7). Lack of reasonable expectation of significant improvement in the parent's conduct in the near future may be evidenced by substance abuse or chemical dependency that renders the parent unable to exercise or incapable of exercising parental responsibilities without exposing the child to a substantial risk of serious harm, according to expert opinion or an established pattern of behavior. La. Ch. Code art. 1036D(1).

Minnesota

The court may terminate parental rights if it finds that reasonable efforts, under court direction, have failed to correct the conditions that led to a determination of neglect or dependency or of a child's need for protective services. The law creates a presumption that such reasonable efforts have failed if the parent has been diagnosed as chemically dependent by a

professional certified to make the diagnosis; has been required by a case plan to participate in a culturally, linguistically, and clinically appropriate chemical dependency program; has either failed two or more times to successfully complete a treatment program or has refused at two or more separate meetings with a caseworker to participate in a treatment program and continues to abuse chemicals. Minn. Stat. §260.221(a)(5).

New York

The court may grant a prerequisite to an adoption order if the parent has failed for a period of more than 1 year after the child came into the system, to substantially and continuously or repeatedly maintain contact with or plan for the future of the child, unless unable to do so. A parent is not deemed unable to maintain contact with or plan for the future of the child by reason of the use of alcohol or drugs, except while actually hospitalized or institutionalized. N.Y. Soc. Serv. Law §384-b-4(d),7(a),(d).

Also, New York law defines "neglected child" (a prerequisite to an adoption order) as one whose physical, mental, or emotional condition is impaired as a result of a parent misusing drugs or alcohol to the extent of the loss of self-control, unless the parent is voluntarily and regularly participating in a rehabilitative program. N.Y. Family Ct Act§ 1012(f)(i)(B).

North Carolina

North Carolina law allows the termination of parental rights if the parent has willfully left the child in foster care for more than 12 months without showing, to the satisfaction of the court, that reasonable progress under the circumstances has been made within 12 months in correcting those conditions that led to the removal of the child. In addition, parental rights may be terminated if the parent is incapable of providing for the proper care and supervision of the child, and there is a reasonable probability that such incapability, which may be the result of substance abuse, will continue for the foreseeable future. N.C. Gen. Stat. §7A-289.32.

South Carolina

If it is in the best interest of the child, parental rights can be terminated if the parents has a diagnosable condition, including drug or alcohol addiction, and the condition makes the parent unlikely to provide minimally acceptable care for the child. It is presumed that the parent's condition is unlikely to change within a reasonable time upon proof that the parent has been required by the court to participate in a treatment program for alcohol or drug addiction, and the parent has failed two or more times to complete the program successfully, or has refused at two or

more times in meetings with the foster care department to participate in a treatment program. S.C. Code Ann. §20-7-1572 (Law. Co-op. Supp. 1996).

Texas

Parental substance abuse constitutes grounds for termination of parental rights if it endangered the health and safety of the child and the parent failed to complete a court-ordered substance abuse treatment program; or if the parent used a controlled substance repeatedly, after completion of a court-ordered substance abuse treatment program, in a manner that endangered the health and safety of the child. This excludes alcohol, tobacco, and drugs obtained by lawful prescription and over-the-counter medications. Tex. Fam. Code§ 161.001(1)(P).

Washington

A petition seeking termination of parental rights must allege that there is little likelihood that conditions will be remedied so that the child can be returned to the parent in the near future. In determining whether conditions will be remedied, the court may consider if there is present the use of intoxicating or controlled substances so as to render the parent incapable of providing proper care for the child for extended periods of time and documented unwillingness of the parent to receive and complete treatment or documented multiple failed treatment attempts. Wash. Rev. Code Ann. §13.34.180(5)(a) (West 1993).

Also, if the court has ordered a child removed from the home, the court may order that a petition seeking termination of the parent and child relationship be filed if in the best interests of the child and that it is not reasonable to provide further services to reunify the family because the existence of aggravated circumstances make it unlikely that services will effectuate the return of the child to its parents in the near future. In determining whether such circumstances exist, the court is to consider if the parent has failed to complete court-ordered treatment where such failure has resulted in a prior termination of parental rights to another child and the parent has failed to effect significant change in the interim. Wash. Rev. Code Ann. §13.34.130(2)(f) (West 1993).

West Virginia

The court may terminate parental rights upon a finding that parents have habitually abused or are addicted to alcohol, controlled substances, or drugs, to the extent that proper parenting skills have been seriously impaired and such persons have not responded to or followed through with the recommended and appropriate treatment that could have

improved the capacity for adequate parental functioning. W. Va. Code§ 49-6-5(a)(6),(b)(1).

Comments From the Department of Health and Human Services

DEPARTMENT OF HEALTH & HUMAN SERVICES — Office of Inspector General

Washington, D.C. 20201

AUG 18 1998

Mr. Mark V. Nadel
Associate Director,
Income Security Issues
United States General
Accounting Office
Washington, D.C. 20548

Dear Mr. Nadel:

Enclosed are the Department's comments on your draft report, "Foster Care: Parental Substance Abuse Presents Obstacles for Securing Safe, Permanent Homes for Children." The comments represent the tentative position of the Department and are subject to reevaluation when the final version of this report is received.

The Department appreciates the opportunity to comment on this draft report before its publication.

Sincerely,

June Gibbs Brown
Inspector General

Enclosure

The Office of Inspector General (OIG) is transmitting the Department's response to this draft report in our capacity as the Department's designated focal point and coordinator for General Accounting Office reports. The OIG has not conducted an independent assessment of these comments and therefore expresses no opinion on them.

COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES ON THE U.S. GENERAL ACCOUNTING OFFICE'S DRAFT REPORT, FOSTER CARE: PARENTAL SUBSTANCE ABUSE PRESENTS OBSTACLES FOR SECURING SAFE, PERMANENT HOMES FOR CHILDREN (GAO/HEHS-98-182)

General Comments

The Department appreciates the opportunity to review and comment on this draft report. We want to thank the General Accounting Office (GAO) for their attention to the critical issue of substance abuse and child abuse and neglect. We are really quite early in our understanding of the impact, prognosis, treatment strategies and outcomes related to substance abusing families, who maltreat their children. In addition, we need to learn much more about service coordination strategies. These areas require more study, demonstration and evaluation.

The ability to deal with the recovery issues and the critical need for safety and permanence for children in the context of the Adoption and Safe Families Act of 1997 will be a challenge for child welfare, substance abuse and mental health agencies. The new provisions which reinforce safety considerations and require timely decisions in the context of a recovery process that is prolonged will need to be addressed by the fields of substance abuse and child welfare.

We are engaged in a further study of these issues as required by Congress. It is our hope that this effort will be complimentary and will further our ability to provide safety and permanency in families where addiction is a problem.

This report raises a number of significant issues regarding the systemic nature of the problem:

- the ability to service a large number of families with substance abuse problems in light of limited treatment services resources;

- the complexity of coordinating substance abuse treatment services and child welfare services including the daily conditions faced by workers in these systems with regard to training issues, budget issues, information systems and service delivery methods;

- the dynamics of substance abuse and its interaction with poverty, mental illness and other socioeconomic issues that contribute to a lack of permanency for children; and

- the need for data that clarifies whether most parents fail to complete treatment due to (a) lack of availability of treatment services, (b) mismatches between the type or intensity of available treatment and the needs of a client, or (c) the fact that the nature of addiction makes the client population often respond poorly even to appropriate treatment services.

In sum, we fully support the GAO's evaluation of this important issue and are available to provide whatever assistance we can in the final revision and editing of this report.

GAO Contacts and Staff Acknowledgments

GAO Contacts

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Staff Acknowledgments

In addition to those named above, John G. Smale, Jr., and Joel I. Grossman conducted the statistical analysis of the questionnaire data results, Ann T. Walker led the development and administration of the questionniare, Karen Doris Wright assisted with the administration of the survey, and Jonathan H. Barker conducted the research and analysis of state laws.

Related GAO Products

Drug Abuse: Research Shows Treatment Is Effective, but Benefits May Be Overstated (GAO/HEHS-98-72, Mar. 27, 1998).

Parental Substance Abuse: Implications for Children, the Child Welfare System, and Foster Care Outcomes (GAO/T-HEHS-98-40, Oct. 28, 1997).

Child Protective Services: Complex Challenges Require New Strategies (GAO/HEHS-97-115, July 21, 1997).

Foster Care: State Efforts to Improve the Permanency Planning Process Show Some Promise (GAO/HEHS-97-73, May 7, 1997).

Drug and Alcohol Abuse: Billions Spent Annually for Treatment and Prevention Activities (GAO/HEHS-97-12, Oct. 8, 1996).

Cocaine Treatment: Early Results From Various Approaches (GAO/HEHS-96-80, June 7, 1996).

Child Welfare: Complex Needs Strain Capacity to Provide Services (GAO/HEHS-95-208, Sept. 26, 1995).

Foster Care: Health Needs of Many Young Children Are Unknown and Unmet (GAO/HEHS-95-114, May 26, 1995).

Foster Care: Parental Drug Abuse Has Alarming Impact on Young Children (GAO/HEHS-94-89, Apr. 4, 1994).

Drug Abuse: The Crack Cocaine Epidemic: Health Consequences and Treatment (GAO/HRD-91-55FS, Jan. 30. 1991).

Drug-Exposed Infants: A Generation at Risk (GAO/HRD-90-138, June 28, 1990).

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