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Report to Congressional Committees

January 2013

CHILD WELFARE

States Use Flexible Federal Funds, But Struggle to Meet Service Needs

GAO-13-170

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GAO Highlights

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Highlights of GAO-13-170, a report to Congressional Committees

Why GAO Did This Study

In fiscal year 2011, over 675,000 children were found to be victims of abuse or neglect. To help ensure that such children have safe and permanent homes, state and local child welfare agencies secure child welfare services, such as parenting classes and substance abuse treatment. Title IV-B of the Social Security Act is the primary source of federal funding designated for child welfare services that is available to states. In fiscal year 2012, Congress appropriated $730 million under Title IV-B. Although states augment these funds with state, local, and other federal funds, some children and families may not receive the services they need. Congress mandated that GAO provide information about the funding and provision of child welfare services. This report addresses: (1) how selected states use funds provided under Title IV-B, (2) what alternative sources of federal funding states use to fund child welfare services and other activities covered under Title IV-B, and (3) what services, if any, child welfare agencies have difficulty securing for children and their families. To answer these questions, GAO reviewed relevant laws, regulations, guidance, and reports; analyzed HHS expenditure data and program evaluations; and interviewed HHS officials, child welfare experts, and state and local child welfare officials in 4 states and 13 localities selected to illustrate a variety of approaches to financing and delivering services. GAO also reviewed state fiscal year 2011 expenditure data from selected states and administered a data collection instrument to selected localities.

View GAO-13-170. For more information, contact Kay Brown at (202) 512-7215 or brownke@gao.gov.

What GAO Found

The four states GAO selected used funds provided under Title IV-B of the Social Security Act for a variety of child welfare services and other activities, and had different strategies for spending these funds. For instance, in fiscal year 2011 Virginia provided funding to all local child welfare agencies to spend on their own priorities, such as parenting classes. New Mexico targeted certain counties for services, such as intensive in-home services for families at risk of foster care.

States nationwide also use other federal funds, such as Temporary Assistance for Needy Families (TANF) and Social Services Block Grant (SSBG) funds, as well as Medicaid, for purposes covered under Title IV-B. In the spring of 2011, 31 states reported spending TANF funds, and in fiscal year 2010, 44 states reported spending SSBG funds on these purposes. Some states also claim federal Medicaid reimbursement for activities covered under Title IV-B. One selected state, Minnesota, claimed reimbursement for case management for children at risk of foster care placement in 2011. Funds authorized under Title IV-E of the Social Security Act make up the large majority of federal child welfare funds, but are designated for purposes such as providing room and board payments for children in foster care and subsidies to adoptive parents, and generally cannot be used for child welfare services. However, 14 states have waivers allowing them to use these funds more flexibly to improve child and family outcomes. Among GAO's selected states, Florida had a waiver allowing it to use some Title IV-E funds for in-home services designed to prevent foster care placement.

Many services, including substance abuse treatment and assistance with material needs, such as housing, are difficult for child welfare agencies to secure due to a variety of challenges. A 2008-2009 U.S. Department of Health and Human Services (HHS) survey that sampled children and families in the child welfare system found that many did not receive needed services. For example, an estimated 58 percent of children age 10 and under at risk of emotional, behavioral, or substance abuse problems had not received related services in the past year. Local child welfare officials in four selected states reported service gaps in multiple areas, as seen in Figure I. Service gaps may harm child well-being and make it more difficult to preserve or reunite families. For example, officials from one locality noted 2- to 3-month wait times for substance abuse services. Due to the chronic nature of the disease, delays in receiving services may make it more difficult to reunify families within mandated deadlines. Officials cited factors contributing to service gaps that included provider shortages and lack of transportation. Additionally, officials noted difficulty securing services from partner agencies, such as housing authorities. State fiscal constraints, which affect both child welfare and partner agencies, contribute to such difficulties.

Figure I: Most Common Service Gaps Reported by 13 Selected Localities

Source: GAO analysis of information provided by child welfare officials in 13 selected localities.

Contents

Abbreviations

ACF	Administration for Children and Families
CAPTA	Child Abuse Prevention and Treatment Act
CBCAP	Community-Based Child Abuse Prevention
CHIP	Children's Health Insurance Program
CMS	Centers for Medicare and Medicaid Services
CWS	Stephanie Tubbs Jones Child Welfare Services
HHS	Department of Health and Human Services
HUD	Department of Housing and Urban Development
NSCAW	National Survey of Child and Adolescent Well-Being
PSSF	Promoting Safe and Stable Families
SAMHSA	Substance Abuse and Mental Health Services Administration
SSBG	Social Services Block Grant
TANF	Temporary Assistance for Needy Families

GAO
Accountability * Integrity * Reliability

United States Government Accountability Office
Washington, DC 20548

January 30, 2013

The Honorable Max Baucus
Chairman
Committee on Finance
United States Senate

The Honorable Orrin G. Hatch
Ranking Member
Committee on Finance
United States Senate

The Honorable Dave Camp
Chairman
Committee on Ways and Means
House of Representatives

The Honorable Sander M. Levin
Ranking Member
Committee on Ways and Means
House of Representatives

In fiscal year 2011, states reported that over 675,000 children were victims of maltreatment, often abused or neglected by their parents. To help ensure that children affected by abuse and neglect have safe and permanent homes, the federal government provides states with funding to assist them in carrying out state and local child welfare programs.[1] Services designed to ensure that children live in safe and permanent homes, either with their parents or with other caregivers, are commonly referred to as child welfare services. Such services may include parenting classes, mental health counseling, and substance abuse treatment. In many cases, services aim to improve how a family functions so that children can remain safely at home or return home from foster care.

Funds provided under Title IV-B of the Social Security Act (Title IV-B) are the chief source of federal support explicitly targeted at child welfare

[1]Federal funding is also provided to assist territories and tribes in carrying out their child welfare programs.

services. In fiscal year 2012, Congress appropriated $730 million under Title IV-B. The Administration for Children and Families (ACF) within the U.S. Department of Health and Human Services (HHS) distributes Title IV-B funding to state child welfare agencies. In addition to Title IV-B funds, states may also use state, local, and other federal funds to support services to children and families. Some of these other federal funds are not specifically designated for child welfare, but states are allowed to use them to fund some services to children and families in the child welfare system. For instance, Social Services Block Grant (SSBG) goals include preventing or remedying child abuse; a wide variety of services, including parent education and training, may be supported with these funds. While other federal funding sources like SSBG may be used for purposes similar to those of Title IV-B, the service needs of children and families are complex, and agencies may face difficulty meeting them.

Congress mandated in the Child and Family Services Improvement and Innovation Act of 2011 (which extended funding authorization for Title IV-B) that GAO explore issues related to federal funding sources for child welfare services and family service needs.[2] This report addresses: (1) how selected states use funds provided under Title IV-B, (2) what alternative sources of federal funding states use to fund child welfare services and other activities covered under Title IV-B, and (3) what services, if any, child welfare agencies have difficulty securing for children and their families.

To answer our research objectives, we reviewed relevant federal laws, regulations, and guidance, as well as past GAO reports related to child welfare funding and services. We used a survey of states funded by the Annie E. Casey Foundation and Casey Family Programs to identify sources of federal funding commonly used by child welfare agencies.[3] As a result of this survey's findings, we analyzed data from a federal Temporary Assistance for Needy Families (TANF) expenditure report and reviewed data from an SSBG expenditure report.[4] We also reviewed data

[2]Pub. L. No. 112-34, §102(f), 125 Stat. 369, 372 (2011).

[3]DeVooght et al., *Federal, State, and Local Spending to Address Child Abuse and Neglect in SFYs 2008 and 2010* (Washington, D.C.: Annie E. Casey Foundation and Casey Family Programs, June 2012).

[4]National data on child welfare agency expenditures of Medicaid funds—the other key source of federal funding cited in this report—were not available.

on service needs and service receipt from ACF's National Survey of Child and Adolescent Well-Being (NSCAW) and analyzed findings on the availability of services from an aggregate ACF report on its Child and Family Services Reviews.[5] Further, we used data from a survey funded by Casey Family Programs to describe waiting lists for various types of child welfare prevention services reported by states. We determined through interviews with knowledgeable officials and reviewing existing information about the data that the data sources cited above were sufficiently reliable for our purposes. Lastly, in response to our Congressional mandate, we reviewed academic studies that explored the impact of substance abuse treatment on family reunification outcomes.

To complement information available from national data sources, we also conducted site visits to four states—Florida, Minnesota, New Mexico, and Virginia—and three to four localities within each state. We visited state and local agencies in Florida, New Mexico, and Virginia, and interviewed officials in Minnesota by phone. We chose our four states to reflect diversity in poverty levels and child welfare agency characteristics of interest, including state vs. local administration,[6] use of differential response models,[7] and experimental child welfare funding and service delivery practices. Within each state, we selected localities based on criteria including urban/rural mix; tenure of local child welfare leadership; and community challenges, such as high substance abuse rates. Our selected state and local child welfare agencies serve as illustrations of state and local experiences; they are not representative of child welfare agencies nationwide. We reviewed select state and local needs assessments and other relevant documentation, and administered a data collection instrument to local officials about service needs and gaps. We also analyzed state fiscal year 2011 expenditure data for our four selected states. We interviewed knowledgeable officials about these data and compared the data with other relevant information, and determined

[5]We used standard errors provided by HHS to calculate 95-percent confidence intervals for NSCAW statistics cited in this report.

[6]States vary in how they fund and organize their child welfare programs. The majority of states administer their child welfare programs centrally, but some supervise child welfare programs that are administered by localities.

[7]Differential response is a child protective service practice that generally involves two "tracks" or paths of response to reports of child abuse and neglect: traditional investigation for higher-risk cases and assessments or alternative responses for low- to moderate-risk cases.

them to be sufficiently reliable for our purposes. We used these data to identify expenditures of federal funds that appeared to be for purposes covered under Title IV-B. We excluded foster care maintenance payments and adoption subsidies from the scope of our review, because they are typically not covered under Title IV-B. Due to their similarity to foster care maintenance payments and adoption subsidies, we also excluded maintenance payments made to relative caregivers of children in foster care and subsidies to relatives who become legal guardians of children leaving foster care. We interviewed ACF officials and various child welfare experts who had published reports on topics relevant to our research questions. We also conducted a discussion group with officials from seven state child welfare agencies at ACF's 18th National Conference on Child Abuse and Neglect. We assembled officials for the discussion group with the help of the American Public Human Services Association and the National Association of Social Workers.

We conducted this performance audit from January 2012 through January 2013 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

In 2011, an estimated 6.2 million children were referred to child welfare agencies by sources including educators, law enforcement officials, and relatives because they were allegedly maltreated. After an initial screening process, agencies conducted abuse or neglect investigations and assessments on behalf of more than half of these children.[8] Over 675,000 children were found to be the victims of abuse or neglect. Many of the children (both victims and non-victims) who were referred to child welfare agencies, as well as their caregivers and families, received some child welfare services, such as in-home services and counseling or other

[8]In an assessment, otherwise known as an alternative response, the caseworker does not generally make a determination regarding whether the abuse or neglect allegation was founded. Instead, the caseworker assesses what the family's needs are, and may offer services to address those needs.

mental health services.[9] Child welfare agencies also conduct activities referred to in the report as non-service related. These non-service-related activities include investigating allegations of abuse or neglect (known as child protective investigations), providing case management for children at home or in foster care, training staff, and administering programs.[10] Further, child welfare agencies make payments to caregivers of children in foster care (maintenance payments) and to adoptive parents of former foster children and other eligible children with special needs (adoption subsidies).[11]

Child Welfare Services

Children referred to child welfare agencies as well as their families may need a variety of services. Families may need services to prevent child abuse or neglect, or to help stabilize the family if abuse or neglect has occurred so that the child can safely remain at home. If it is not in a child's best interest to remain at home, the child may be placed in foster care. In these cases, services may be offered to help the family reunite. If reunification is not possible, services may be needed to encourage adoption and support adoptive families. Some common types of child welfare services are listed in table 1, below.

[9]Child welfare services are generally defined in HHS regulations as public social services directed toward protecting and promoting the welfare of all children, preventing or remedying child neglect or abuse, and preventing the unnecessary separation of children from their families. Services also help ensure that children are adequately cared for away from their homes, safely restored to their families, and placed in suitable adoptive homes when returning them to their families is not possible. 45 C.F.R. § 1357.10(c).

[10]Case management involves assessing the needs of a client and client's family, and arranging, monitoring, evaluating, and advocating for a package of services to meet those needs.

[11]These payments may also be made on behalf of children with special needs who are eligible to receive Supplemental Security Income benefits.

Table 1: Common Types of Child Welfare Services

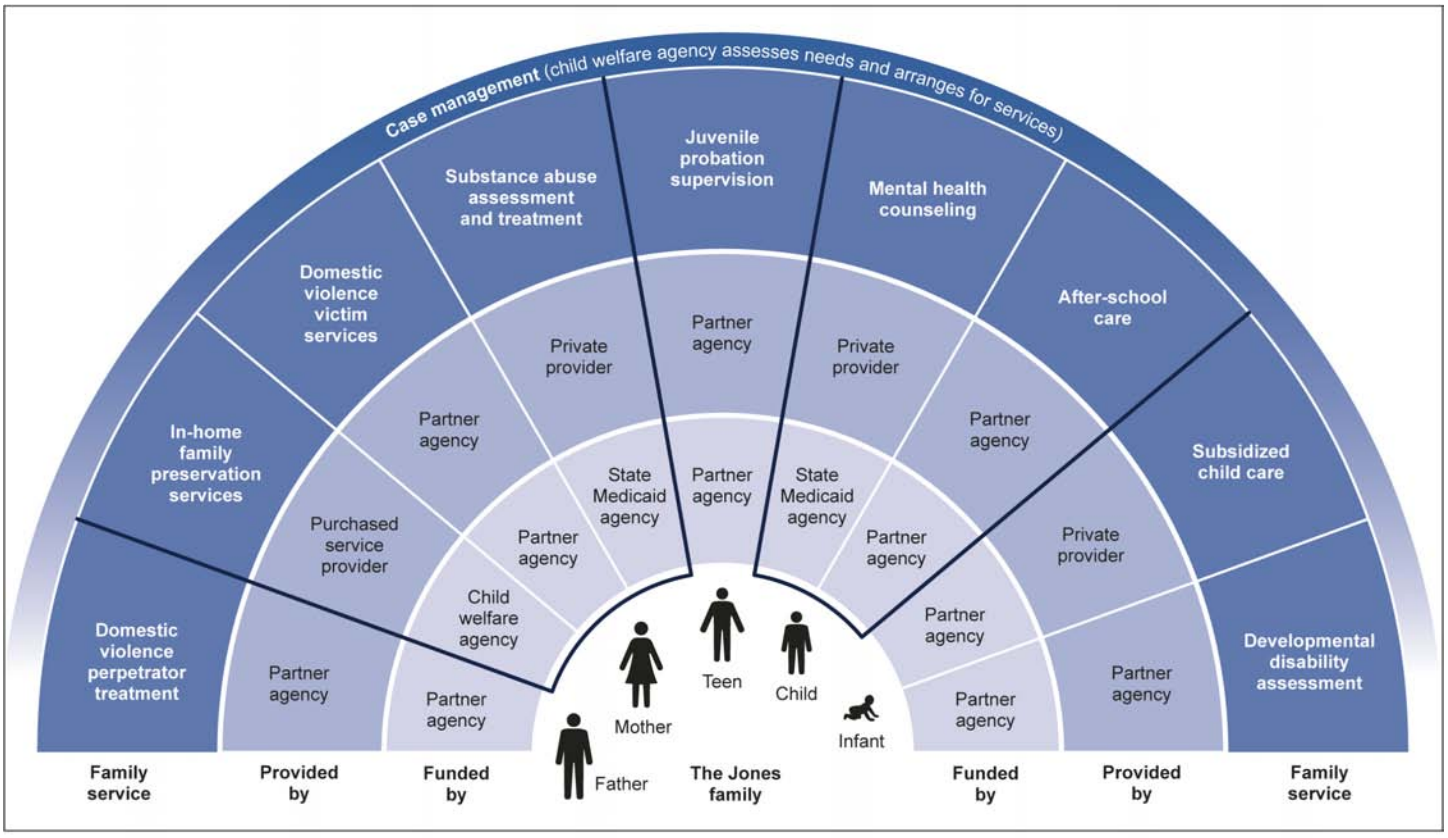
Service type	Service description
Home visiting programs	Typically involve trained personnel visiting parents and children in their homes to provide support and education in order to prevent child maltreatment.
In-home services	May include intensive family preservation services when a child is at immediate risk of being removed from home, and longer-term family support services. These services may include teaching parents to prevent accidents and injuries by making the home environment safer and hazard free.
Parent education and training	Usually center-based and delivered in groups, aiming to prevent child maltreatment by improving child-rearing skills, increasing parental knowledge of child development, and encouraging positive child management strategies.
Respite care or crisis nurseries	For caregivers in stressful situations, respite care services provide temporary relief from the ongoing responsibilities of caring for children in the home. These services provide short-term care to children who have disabilities or chronic or terminal illnesses, who are in danger of abuse or neglect, or who have experienced abuse or neglect.
Parent support	May include parent mentor programs with stable, non-abusive families acting as “role models” and providing support to families in crisis, or parent support groups that help parents transform negative practices and beliefs into positive parenting behaviors and attitudes.
Material supports (including housing)	May include vouchers, subsidies, or other assistance to help families obtain child care, clothing, transportation, housing, employment or meet other material needs.
Counseling/ mental health services	Includes mental health services for children and families affected by maltreatment to improve family communication and functioning.
Substance abuse assessment and treatment	May include screening for substance abuse, Family Treatment Drug Courts, services for substance-exposed infants, and referrals or direct provision of substance abuse services.
Domestic violence services	May include assessment, safety planning or analysis of safety threats, legal or therapeutic interventions for perpetrators, and referrals to a domestic violence advocate or other needed services.

Source: Information provided to GAO by Child Trends.

Child welfare agencies secure services in a variety of ways. Child welfare agency staff may provide some services directly in addition to carrying out typical case management duties. Child welfare agencies may also rely on contractors, also called purchased service providers. Another way child welfare agencies secure services is by relying on partner agencies, such as behavioral health agencies and public housing authorities. These

agencies serve families in the child welfare system in addition to clients who are not in the child welfare system. Child welfare agencies also refer individuals for medical services. Medical services may be supported in a variety of ways, including through Medicaid or private health insurance.[12] Figure 1, below, is an example of how a child welfare agency might meet—using various providers and funding sources—a hypothetical family's diverse service needs.

Figure 1: Example of Types of Services and Providers a Child Welfare Agency May Secure to Meet the Needs of a Hypothetical Family



Source: GAO analysis of sample case provided by local child welfare agency.

[12]Medicaid is a joint federal-state program that finances health care services for certain low-income individuals, nearly half of whom are children.

State and Local Child Welfare Agencies

States are chiefly responsible for funding and administering child welfare programs. Most states administer their child welfare programs centrally. However, in some states, local agencies administer their own child welfare programs, with supervision from the state. To varying degrees, these agencies use a combination of state, local, and federal funds to support their programs. According to a survey of states funded by the Annie E. Casey Foundation and Casey Family Programs, in state fiscal year 2010, 46 percent of all child welfare expenditures were from federal sources, while 43 percent and 11 percent were from state and local funds, respectively.[13] Among federal funds used for child welfare purposes, states use a combination of funding designated solely for child welfare purposes and other sources of funding with broader aims.

Federal Funds Dedicated to Child Welfare

Title IV-B is the primary source of federal child welfare funding available for child welfare services, representing about 9 percent of dedicated federal child welfare appropriations ($730 million of $8 billion) in fiscal year 2012. In addition to child welfare services, Title IV-B funding may also be used for a variety of other activities, such as child protective investigations and case management. Child welfare agencies may spend Title IV-B funds on behalf of any child or family. They receive these funds primarily though two formula grant programs: the Stephanie Tubbs Jones Child Welfare Services program (CWS) under Subpart I of Title IV-B, and the Promoting Safe and Stable Families child and family services program (PSSF) under Subpart II. About $281 million in CWS funds and $328 million in PSSF funds were provided to states, territories, and tribes in fiscal year 2012.[14] The purposes of Title IV-B's two main funding streams are similar, as seen in table 2, below, although CWS funds may be used for a broader array of activities. States may spend CWS funds on any service or activity that meets the program's broad goals, which include protecting and promoting the welfare of all children. Ninety percent of PSSF funds must be spent within four required categories:

[13]DeVooght et al., "Federal, State, and Local Spending."

[14]Congress appropriated an additional $121 million under Title IV-B for fiscal year 2012 for a variety of grants and initiatives. The total appropriation comprised $61 million for a variety of competitive grants (including initiatives that address parental substance abuse and expand activities that engage families in efforts to remedy abuse and neglect), $20 million for formula grants to states to improve caseworker visits, $32 million for formula grants to improve the handling of child welfare cases in court, and $8 million for HHS-conducted research.

family support, family preservation, time-limited family reunification, and adoption promotion and support.

Table 2: Purposes and Selected Requirements of Title IV-B Subpart I Child Welfare Services and Subpart II Promoting Safe and Stable Families Programs

Program	Purposes	Requirements
Subpart I: Child Welfare Services Program	Protect and promote the welfare of all children Prevent child abuse and neglect Enable children to remain with or return to their families when it is safe and appropriate Promote the safety, permanence, and well-being of children in foster care and adoptive families Provide training, professional development, and support to ensure a well-qualified child welfare workforce	States must ensure that all children in foster care receive case review and permanency planning. States are limited in using funds for child care, foster care maintenance payments, and adoption assistance payments. No more than 10 percent of expenditures may be used for administration.
Subpart II: Promoting Safe and Stable Families Program	Services intended to prevent maltreatment among at-risk families Services intended to assure children's safety within the home and preserve intact families in which children have been maltreated Services intended to address problems of families whose children have been placed in foster care in a timely manner so reunification can occur Services intended to provide adoptive families the supports necessary for them to make a lifetime commitment to children	States must spend at least 90 percent of funds on services that fall into four categories—family support, family preservation, time-limited family reunification, and adoption promotion and support—with approximately 20 percent of total expenditures in each category. No more than 10 percent of expenditures may be used for administration.

Source: GAO analysis of Title IV-B of the Social Security Act and associated regulations and guidance

Note: States that spent CWS funds on child care, foster care maintenance payments, or adoption assistance payments in fiscal year 2005 may continue to do so, but may not exceed 2005 expenditure amounts in these categories. 42 U.S.C. § 624(d).

Funds authorized under Title IV-E of the Social Security Act make up the large majority of federal funding dedicated to child welfare, with funds chiefly available for specific foster care and adoption expenses, but not for services. Congress appropriated $7.1 billion under Title IV-E in fiscal year 2012 (89 percent of federal child welfare appropriations), in general to partially reimburse states for expenditures on behalf of eligible children and youth who are in foster care, have left care for adoption or guardianship, or

are aging out of care without adoptive homes.[15] Title IV-E funds may be used to reimburse states for a portion of room and board (maintenance) expenses for eligible children in foster care, and for the costs of subsidies to parents who adopt eligible children with special needs (adoption assistance). States participating in the Guardianship Assistance Program may also receive Title IV-E reimbursement for a portion of assistance payments provided to relatives who become guardians (known as kinship guardians) of eligible children in foster care.[16] States may also use Title IV-E funds to support case planning for eligible children in foster care, and for administration and training costs associated with eligible foster children and children adopted out of foster care. Additionally, states may use Title IV-E funds available through the Chafee Foster Care Independence Program and Education and Training Vouchers to support youth who are transitioning out of foster care without a permanent home, youth who have been adopted out of foster care after age 16, and youth who have entered into kinship guardianships after age 16.

The funds provided under Title IV-E serve as an open-ended entitlement to support the costs of caring for eligible children in foster care. However, there is no similar entitlement to preventive services for children at risk of entering into foster care. Experts and policymakers have expressed concerns that the federal funding structure for child welfare encourages reliance on foster care and does not grant states flexibility to support services designed to reduce the need for foster care. However, Congress authorized HHS to waive certain Title IV-E funding restrictions so that states with approved demonstration projects may spend those funds

[15]In fiscal year 2010, roughly 44 percent of children in foster care received Title IV-E assistance, based on criteria including family income and placement with licensed foster care providers. The proportion of children in foster care receiving support under Title IV-E declined from 52 percent in fiscal year 2000. This reduction is due to factors including income eligibility standards, which have not changed since 1996, as well as reductions in the total number of children entering foster care and increased adoptions, which have contributed to declines in the overall population of children in foster care.

[16]The Fostering Connections to Success and Increasing Adoptions Act of 2008 gave states the option to use federal Title IV-E funding—that was previously reserved for foster care and adoption services—to support relatives who become guardians under certain circumstances. Pub. L. No. 110-351, § 101(a), 122 Stat. 3949, 3950. To receive funding, the child must be Title IV-E eligible, the caregiver must be a licensed or approved foster parent, and the child must live with the caregiver for at least 6 months. In addition, reunification with the child's birth parents and adoption by the relatives must be ruled out as permanency options. Through kinship guardianship, a relative assumes legal guardianship over a child or youth without the termination of that child's parents' rights.

more flexibly. In order to be granted a waiver, states must demonstrate that their projects are cost-neutral to the federal government, among other requirements. States must also conduct an evaluation (carried out by an independent contractor) of project success in improving child and family outcomes. HHS' authority to issue these waivers lapsed in 2006 but was renewed by Congress in 2011.[17]

Congress also appropriated $189 million in fiscal year 2012 (2 percent of federal child welfare appropriations) under the Child Abuse Prevention and Treatment Act (CAPTA) and a variety of other programs and initiatives, much of which was not directed explicitly to child welfare agencies and could be available to partner agencies and community-based organizations as well.[18] These programs and initiatives included competitive grants for purposes including eliminating barriers to adoption and providing services to abandoned children.[19]

[17]Pub. L. No. 112-34, § 201, 125 Stat. 369, 378 (2011).

[18]CAPTA appropriations (which totaled $94 million for fiscal year 2011) included $26 million in formula grants provided to state child welfare agencies to help improve child protective service systems. However, other funds were not directed explicitly to child welfare agencies. Specifically, Congress appropriated $26 million in competitive grants under CAPTA for demonstration, research, or other activities to prevent or treat child maltreatment. It also appropriated $42 million in Community-Based Child Abuse Prevention (CBCAP) formula grants. CBCAP grants are awarded to state-appointed lead entities (including some state child welfare agencies) for community-based child abuse and neglect activities.

[19]Specifically, Congress appropriated $44 million in child welfare funds for states under the Children's Justice Act and for organizations under the Victims of Child Abuse Act for grants generally related to improving the handling of child abuse and neglect cases. Congress also appropriated $39 million under the Adoption Opportunities Program for competitive grants to eliminate barriers to adoptions, and $12 million under the Abandoned Infants Assistance program for competitive grants to prevent child abandonment and to serve abandoned children.

Selected States Used Title IV-B Funds to Support a Wide Array of Services, and Strategies for Using These Funds Varied

Officials from the four states we studied reported spending Title IV-B CWS funds in state fiscal year 2011 to support a variety of services and other activities, and they told us they largely spent PSSF funds for services in the program's four required expenditure categories. With respect to CWS, Virginia used these funds for case management costs for children in foster care who were not eligible for Title IV-E funding. Florida allocated over two thirds of CWS funds for case management costs for children living at home, out of the home, or with adoptive families. Florida spent almost one third of CWS funds on children's legal services, and limited funds on administration and training. Minnesota officials reported spending CWS funds on licensing staff, other state level expenses, quality assurance, and program administration. New Mexico largely spent CWS funds on foster care maintenance payments, which is permitted in limited circumstances. States report annually to ACF on how they plan to spend Title IV-B funds within specific categories. For fiscal year 2012, states nationwide planned to spend 32 percent of CWS funds on child protective investigations and related activities. Other common planned expenditure categories were family preservation services (18 percent), family support services (13 percent), time-limited family reunification services (11 percent), and foster care maintenance payments (10 percent).[20]

Our four selected states had different strategies for managing PSSF expenditures, but state officials told us they largely spent PSSF funds on the four expenditure categories required under the program in state fiscal year 2011. (Nationally, states planned to spend 90 percent of PSSF funds within these categories for fiscal year 2012.[21]) Two states—Florida and Virginia—allowed local child welfare agencies to decide how to spend PSSF funding.[22] Both of these states required recipient agencies to contribute local matching funds to the PSSF grants they received. Local officials in these states described using PSSF funds in these four categories to support a wide variety of services and other activities. Funded activities included home visiting programs, parenting classes, and

[20]HHS, *Annual Report to Congress on State Child Welfare Expenditures Reported on the CFS-101* (Washington, D.C.; December 2012).

[21]States reported spending 93 percent of PSSF funds in these categories for fiscal year 2009. States are not required to report actual expenditures for the CWS program.

[22]Virginia managed adoption promotion and support services statewide, and allowed localities to develop their own family support, preservation, and reunification programs.

material supports, such as emergency rent assistance. For instance, one Virginia locality reported spending PSSF family support funds for a home visiting program designed to reduce the risk of abuse and neglect by first-time mothers, and a parenting academy for individuals ordered by the court to attend parenting classes and others found to have neglected or abused their children.

Minnesota distributed some PSSF funds to localities through competitive matching grants targeted at two service areas, and additional funds to all localities for differential response initiatives.[23] The first of these areas focused on family group decision-making practices designed to increase family involvement in decisions about their children's care needs. The second of these areas focused on services to "screened out" families, or families who would not otherwise qualify for ongoing case management or services due to relatively low abuse or neglect risk levels. Some funds were also distributed to localities to support their differential response practices. Minnesota officials said the state began encouraging localities to implement differential response in the early 2000s, and PSSF funds played an integral role in these efforts. State officials said that because Minnesota localities administer and largely fund their own child welfare programs, they had to find creative ways to develop incentives for localities to adopt a differential response model. They decided to leverage PSSF funds along with funding from a private donor to initiate a 4-year pilot project that established differential response in 20 counties.

New Mexico generally distributed PSSF funds to contracted community-based service providers in targeted geographic areas. New Mexico issued family support contracts designed to increase placement stability for children living in foster and adoptive families in 18 counties, and to support children of incarcerated parents in 6 counties.[24] Officials said that placement stability was an area of weakness in New Mexico's last Child and Family Service Review, and that the state worked with ACF to

[23]These activities appeared to be in keeping with PSSF's family support, preservation, and time-limited reunification expenditure categories. Minnesota did not spend PSSF funds on adoption promotion and support services. According to state officials, HHS did not require Minnesota to use PSSF funds for adoption services because it had substantial state funding dedicated to this purpose.

[24]New Mexico officials told us their next round of family support contracts would be targeted at services to birth families, but services would also be available to foster families.

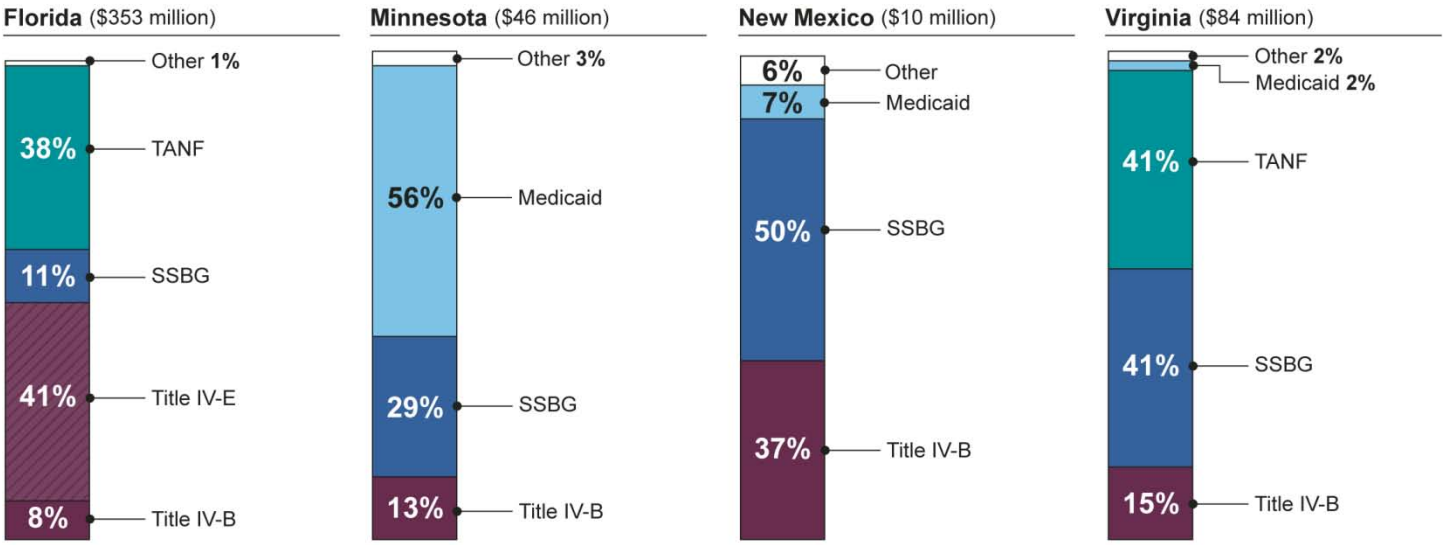
develop this strategy to improve its performance. The state's family preservation contracts covered up to 4 months of intensive in-home services designed to prevent the need to remove children to foster care in families with high levels of safety and risk concerns in eight counties. In addition, time-limited family reunification contracts covered intensive services designed to enable families in 11 counties to reunite with children in foster care within 4 months of referral. New Mexico used PSSF adoption promotion and support funds statewide for activities including home studies, parent training, and a social networking site for adoptive parents.

Most States Rely on Flexible Federal Funding to Provide Additional Support for Child Welfare Services

States Use TANF, SSBG, and Medicaid to Fund Services Also Covered by Title IV-B

Nationally, most states supplement Title IV-B funds with other federal funding that is not dedicated to child welfare, according to expenditure data states reported to ACF. States use widely varying approaches and make different choices about how to spend the federal dollars they receive due to a variety of competing demands. As seen in figure 2 below, our selected states each used different combinations of federal funds not dedicated to child welfare to support services and other activities covered under Title IV-B in state fiscal year 2011. These funding sources were chiefly TANF, SSBG, and Medicaid. Officials in these states told us that they first used the most restrictive federal sources for activities that meet funding criteria and, after those costs were covered, they used more flexible sources to support services and other activities as needed.

Figure 2: Federal Funding Used to Finance Services and Other Activities Covered under Title IV-B for Selected States, State Fiscal Year 2011



Source: GAO analysis of state data.

Note: We did not make a legal determination regarding whether any expenditures in our selected states were allowable under Title IV-B. We excluded Title IV-E expenditures from the scope of our review for Minnesota, New Mexico, and Virginia. For Florida, which has a Title IV-E waiver, we excluded only Title IV-E expenditures on foster care maintenance payments and adoption subsidies. We also excluded Title IV-B expenditures on foster care maintenance payments in New Mexico, as these expenditures are only covered in limited circumstances. Minnesota reported calendar year 2011 data on county expenditures and 2011 state fiscal year data on state expenditures. We combined these expenditures for our purposes.

Most states across the country, including two of our selected states, chose to use TANF funding for child welfare services and other activities covered by Title IV-B. TANF is a federal block grant that supports four overarching goals, one of which is to provide assistance to needy families so that children can live in their homes or the homes of relatives.[25] Because TANF funds can be spent on essentially any service for eligible

[25]The other three purposes of TANF are ending families' dependence on government benefits by promoting job preparation, work, and marriage; preventing and reducing out-of-wedlock pregnancies; and encouraging two-parent families. Since 1996, Congress has provided $16.5 billion a year in funds to states under TANF. States may spend TANF funds for both cash assistance to low-income families as well as a variety of other services that meet the purposes of TANF. In fiscal year 2011, states spent about 58 percent of federal TANF funds on such services. GAO, *Temporary Assistance for Needy Families: More Accountability Needed to Reflect Breadth of Block Grant Services*, GAO-13-33 (Washington, D.C.: December 6, 2012).

families that aims to achieve one of the program's four goals, it offers states flexible funding that can be used to support child welfare activities. According to national data reported by states to ACF, in the spring of 2011, 31 states spent TANF funds, including state maintenance of effort funds,[26] for purposes covered by Title IV-B.[27] For fiscal year 2011, we estimate these expenditures to have been at least $1.5 billion.[28] Moreover, nationally states reported spending these funds for a variety of purposes. For example, 16 states reported using TANF funds for in-home services, family preservation services, or both.[29] Another 9 states reported using TANF for child protective investigations and related activities. Among the four states we studied, Virginia spent TANF funds on family support and family preservation programs. Florida used TANF for a number of different purposes including case management, child protective investigations, and a state-sponsored home visiting program. New Mexico and Minnesota, in contrast, did not use TANF for child welfare. New Mexico officials said that their state had a relatively high

[26]States are required to maintain a specified level of their own past spending on certain welfare programs, referred to as state maintenance of effort, to receive all of their TANF funds.

[27]HHS, *Engagement in Additional Work Activities and Expenditures for Other Benefits and Services, April-June 2011: A TANF Report to Congress* (Washington, D.C.: February 13, 2012). ACF's TANF expenditure reporting form for states does not provide specific information on state spending for child welfare activities. Under the Claims Resolution Act of 2010, states were required to submit additional information to ACF on certain categories of TANF expenditures for March 2011 and April through June 2011, such as information on state spending for child welfare activities. The act only required these reports in 2011, and did not require ongoing reporting for following years. Pub. L. No. 111-291. 124 Stat.3064, 3160.

[28]To create this estimate, we analyzed descriptions of child welfare expenditures reported under three categories included in HHS, *A TANF Report to Congress*—"other" child welfare payments, "other" child welfare services, and child welfare "authorized solely under prior law"—to determine which expenditures were for purposes covered under Title IV-B. We arrived at an annual estimate by multiplying expenditures for one quarter by four, which is an imperfect method because actual expenditures fluctuate across quarters. Our estimate is also imperfect because, due to reporting limitations, it may exclude some expenditures for purposes covered by Title IV-B. In particular, we excluded some state expenditures because they included both activities covered and not covered under Title IV-B. Additionally, some relevant expenditures may not have been captured by this report. Officials in one selected state, Virginia, told us they reported some child welfare expenditures under categories not covered by ACF's April through June 2011 report.

[29]We analyzed services and other activities states identified under the category "other" child welfare services in HHS, *A TANF Report to Congress*. States also reported child welfare expenditures in two other categories.

poverty rate and spent most of its TANF funds on cash assistance.[30] As a result, New Mexico officials said they had few TANF funds available for other purposes—including child welfare.

Most states, including all four of our selected states, also used SSBG funds for child welfare services and other activities. SSBG is a federal block grant under which states are provided funding to support a diverse set of policy goals.[31] These goals include preventing or remedying child abuse and neglect, preventing or reducing inappropriate institutional care, and achieving or maintaining self-sufficiency.[32] In addition to their annual SSBG allotments, states are permitted to transfer up to 10 percent of their TANF block grant to SSBG. According to ACF data, 44 states including the District of Columbia spent fiscal year 2010 SSBG funding (including TANF transfer funds) in three reporting categories covered by Title IV-B.[33] (Fiscal year 2010 was the most recent year for which national SSBG expenditure data were available.) Specifically, 35 states reported spending $377 million for services to children in foster care and other related activities, which accounted for 13 percent of total SSBG expenditures. Covered activities included, but were not limited to, counseling, referral to services, case management, and recruiting foster parents. Thirty-nine states also reported using $290 million in SSBG funds (10 percent) for child protective investigations and related activities, such as emergency shelter, initiating legal action (if needed), case management, and referral to service providers. Twenty-two states reported spending $31 million on adoption services and other activities, such as counseling, training, and recruiting adoptive parents.[34] All four of

[30]New Mexico reported spending 80 percent of its federal TANF funds on cash assistance during fiscal year 2011. New Mexico did not transfer any TANF funds to SSBG in fiscal year 2011.

[31]For fiscal year 2012, Congress appropriated $1.7 billion in SSBG funds.

[32]42 U.S.C. § 1397.

[33]States may also report expenditures for child welfare purposes covered by Title IV-B in other SSBG reporting categories. For instance, 28 states reported spending $179 million in SSBG funds on prevention and intervention services for fiscal year 2010. However, this reporting category includes services designed to prevent both the abuse and neglect of vulnerable adults as well as children.

[34]State expenditures of TANF transfer funds in each of these three categories included approximately: (1) $249 million for services to children in foster care; (2) $171 million for child protective investigations and related activities; and (3) $10 million for adoption services.

the states we selected to study used SSBG for services and other activities covered by Title IV-B. In state fiscal year 2011, New Mexico used SSBG for purposes including administrative costs associated with child protective investigations, foster care, and adoptions. In that same year, Florida spent SSBG funds on purposes including child protective investigations, child legal services, and the state's hotline for reporting abuse and neglect.

Nationwide, some child welfare agencies also claimed federal Medicaid reimbursement for services they provide to Medicaid beneficiaries.[35] The amount of federal Medicaid reimbursement claimed by child welfare agencies is unknown. Under the Medicaid targeted case management benefit, child welfare agencies can be reimbursed for case management activities designed to assist targeted beneficiaries in gaining access to needed medical, social, educational, and other services.[36] One of our selected states, Minnesota, claimed $24 million in federal reimbursement for Medicaid targeted case management for children at risk of placement in foster care and their families in calendar year 2011.[37] Another selected state, Virginia, reported claiming $1.9 million in federal Medicaid reimbursement for targeted case management activities related to children in foster care in state fiscal year 2011.[38] Child welfare agencies

[35]In order to qualify for Medicaid reimbursement, child welfare agencies must have a provider agreement with the state Medicaid agency.

[36]Covered beneficiaries are targeted primarily on the basis of shared characteristics, and may include children or adults with chronic mental illness or developmental disabilities. There are some circumstances when states are prohibited from claiming Medicaid reimbursement for child welfare activities under the targeted case management benefit. For instance, states may not cover certain case management activities for children in foster care, including arranging foster care placements and conducting home investigations. 42 U.S.C. § 1396n(g)(2), 42 CFR § 441.18(c).

[37]Minnesota also had a targeted case management program for children with serious emotional disturbances, which included some children in the child welfare system. We excluded these expenditures from the scope of our review because the targeted group included children not in the child welfare system.

[38]The Centers for Medicare & Medicaid Services (CMS) must approve amendments to state plans to reimburse and cover Medicaid targeted case management services. CMS officials said the agency had received state plan amendments from six states which were approved since 2009 to make changes to Medicaid targeted case management services. Changes included revising payment for foster care targeted case management (1 state), removing foster care targeted case management from the Medicaid state plan (3 states) and adding or revising coverage or payment to include at-risk children and not restricted to children in the custody of child welfare (2 states).

may also obtain federal reimbursement for services they provide to Medicaid beneficiaries covered under home and community-based service waivers. Under these waivers, states may cover a wide range of services and other activities to allow targeted individuals, such as children with developmental disabilities or serious emotional disturbances who would otherwise require institutional care, to remain at home or live in a community setting. Among our selected states, Minnesota claimed $1.8 million in federal reimbursement for services to children with disabilities under a home and community-based services waiver in calendar year 2011. Child welfare agencies can also claim federal Medicaid reimbursement for administrative case management activities, including making Medicaid eligibility determinations.[39] Two of our selected states—Florida and New Mexico—claimed federal Medicaid reimbursement for administrative costs associated with case management activities. For example, Florida claimed $1.3 million in federal reimbursement for activities that included applying for Medicaid benefits and arranging appointments.[40]

Child welfare agencies nationwide also accessed other federal funding sources dedicated to child welfare to support services and other activities. These other dedicated federal funding sources included CAPTA and ACF discretionary grants. CAPTA funds can be used for a wide variety of purposes. For example, among our four selected states, New Mexico used a $136,000 CAPTA state grant for purposes including training, investigations, and case management in state fiscal year 2011. Florida spent about $1.4 million in CBCAP funds to support its chapter of a child abuse prevention organization, parent leadership and support groups, a child abuse prevention month campaign, and fatherhood initiatives.

Other government entities whose missions intersect with those of child welfare agencies may also use federal funds for purposes covered under Title IV-B for children and families they serve. These entities, such as behavioral health agencies, housing authorities, and the courts, typically serve a broader population than children and families affected by abuse

[39]Child welfare agencies may only perform and receive Medicaid reimbursement for administrative case management activities if the agencies enter into interagency agreements with their state Medicaid agency.

[40]Less than 1 percent of Florida's federal expenditures for purposes covered under Title IV-B were from Medicaid. These expenditures are not reflected in figure 2 above.

or neglect. However, some serve children and families who are also in the child welfare system. These entities may access a variety of federal funds to benefit these children and families. For example:

- Behavioral health agencies that oversee home visiting programs may use Maternal, Infant, and Early Childhood Home Visiting Program funds to provide home visiting services to families at risk of abuse or neglect.[41] They may also access Substance Abuse Prevention and Treatment Block Grant funds for substance abuse treatment for individuals in the child welfare system, including pregnant women and women with dependent children.

- Housing authorities that participate in the U.S. Department of Housing and Urban Development's (HUD's) Family Unification Program may provide housing vouchers to families at risk of losing their children to foster care or who face difficulty achieving family reunification due to inadequate housing.[42]

- Courts receive Court Improvement Program formula grants to improve the handling of child abuse and neglect cases.

Some States Have Waivers that Permit Them to Use Title IV-E Funding for Services Covered under Title IV-B

Although states are generally prohibited from funding services, such as parenting classes and substance abuse treatment, with Title IV-E funds, ACF has granted waivers permitting some states to do so. As of October 2012, 14 states had implemented or were approved to initiate Title IV-E waiver demonstration projects that allow them to use those funds for services covered by Title IV-B.[43] These projects were designed to test new

[41]The Maternal, Infant, and Early Childhood Home Visiting Program was authorized under the Patient Protection and Affordable Care Act. HHS announced $224 million in funding for this program in fiscal year 2011.

[42]These housing vouchers are awarded competitively by HUD. Vouchers are reserved for families for whom the lack of adequate housing is a primary factor in risk of foster care placement or delay in reunification after foster care placement, as well as for youth transitioning out of foster care without a permanent home. The Family Unification Program received a $15 million line item appropriation in both fiscal years 2010 and 2011, but not in fiscal year 2012.

[43]There were 15 demonstration projects in these states—6 were active and 9 were approved. Illinois had an active waiver that focused on substance abuse treatment to enable reunification of children in foster care with their parents as well as a waiver that was approved in 2012 to provide trauma-informed care to young children.

financing and service delivery approaches that may result in lower foster care costs and increased available funding for new or expanded services. States with waivers are required to ensure that their Title IV-E expenditures under the waiver do not exceed what they would have spent without a waiver. These states would be solely responsible for covering additional costs incurred if the number of children in foster care, or costs of caring for such children, exceeded state estimates. States with active and recently approved waivers have used various methods to determine that their projects were cost neutral. First, states with flexible funding waivers agree to receive a capped (or fixed) amount of Title IV-E funding in exchange for flexibility to use those funds for an expanded array of services, similar to a block grant. In other states, the amount of funding received for children participating in the waiver project is determined by the average amount of funding received for children in a control group who are not receiving waiver services, ensuring that funding for the waiver group is comparable to what it would have been without the waiver.

The goals of each Title IV-E waiver project vary and include: (1) reducing the time children and youth spend in foster care and promoting successful transition to adulthood for older youth, (2) improving child and family outcomes, and (3) preventing child abuse and neglect, and the re-entry of children and youth into foster care. ACF encouraged states to develop projects that included evidence-based and evidence-informed practices to promote children's social and emotional well-being and to collaborate with state Medicaid agencies when possible.[44] Approved waiver projects reflect these priorities in a variety of ways (see figure 3). For instance, Illinois plans to provide specialized training to parents and other caregivers of very young children in Cook County who exhibit effects of trauma, using a control- and treatment-group design. Wisconsin plans to implement post-reunification support services, including evidence-based therapies designed to address trauma (trauma-informed care), for families reunified after foster care.

[44]In a recent memo to states, ACF stated that evidence-based and evidence-informed practices are those that show measurable improvements or promising results in aspects of children's well-being, such as decreasing emotional or behavioral symptoms and helping traumatized children and youth form and maintain healthy attachments. HHS, ACF, *Information Memorandum: Promoting Social and Emotional Well-Being for Children and Youth Receiving Child Welfare Services* (Washington, D.C.: April 17, 2012).

Figure 3: Active and Approved Title IV-E Waiver Demonstration Projects

Active waivers	Fixed, flexible funding	Early intervention for young children	Trauma-informed care	Family support/ preservation	Family reunification	Kinship care/ adoption services	Other
California[a] 2 of 58 counties	✓			✓	✓	✓	✓
Florida Statewide	✓			✓	✓	✓	
Illinois 3 of 102 counties					✓		
Indiana[b] Statewide	✓			✓	✓	✓	✓
Ohio[c] 18 of 88 counties	✓			✓	✓	✓	✓
Oregon Statewide	✓			✓	✓		
Approved waivers							
Arkansas Statewide	✓	✓	✓	✓	✓	✓	
Colorado Statewide	✓		✓	✓		✓	
Illinois 1 of 102 counties		✓	✓	✓	✓		
Massachusetts[d] Statewide	✓		✓	✓	✓	✓	✓
Michigan[e] 3 of 83 counties		✓	✓	✓			✓
Pennsylvania[f] 5 of 67 counties	✓		✓	✓	✓	✓	
Utah Statewide	✓		✓	✓			
Washington[g] Statewide	✓		✓	✓			✓
Wisconsin[h] Statewide	✓	✓	✓		✓		

Source: GAO analysis of HHS data.

[a]For California, "other" includes case-specific, time-limited assistance with material needs.

[b]For Indiana, "other" includes case-specific, time-limited assistance with material needs.

[c]For Ohio, "other" includes case-specific, time-limited assistance with material needs.

[d]For Massachusetts, "other" includes congregate care reform.

[e]For Michigan, "other" includes case-specific, time-limited assistance with material needs.

[f]Pennsylvania has a goal of expanding implementation of its Title IV-E waiver to more counties based upon the state's assessment of the readiness and capacity of each additional county.

[g]For Washington, "other" includes case-specific, time-limited assistance with material needs.

[h]Wisconsin plans to test their Title IV-E waiver during the first year in a single county before expanding implementation statewide.

Among the four states we studied, only Florida had an active Title IV-E demonstration waiver project. Florida's waiver demonstration project was implemented in 2006 as part of a statewide reform effort that included transferring management of child welfare cases to community-based lead agencies that work with a network of purchased service providers after the state has concluded its initial child protective investigation. Florida's demonstration waiver goals are to: (1) improve child and family outcomes, (2) expand the array of community-based services and increase the number of children eligible for services, and (3) reduce administrative costs related to service provision.[45]

State and local officials in Florida told us their waiver helped expand services aimed at preventing children from being placed in foster care. From state fiscal years 2005 to 2011, the number of children placed in out-of-home care decreased by 27 percent,[46] as compared to an 18 percent decrease nationwide. Officials from one local lead agency said that the waiver has allowed them to fund a greater variety of preventive services, particularly in-home services. These officials also said that waiver funds have helped them to shore up other areas with funding shortfalls, such as services to youth who are aging out of foster care without a permanent home. However, Florida's waiver evaluation also showed that under the waiver, several key indicators of child well-being either remained unchanged or improved only slightly.

Some officials in selected states without active waivers noted that additional Title IV-E funding flexibility would improve their ability to fund preventive and other non-foster care services. Virginia officials said that they had spent Title IV-E funds available for foster care placement costs (which are administrative in nature) on services to prevent children from being placed in foster care. However, HHS disallowed $28 million of

[45]Under waiver terms negotiated prior to the project's implementation, Florida received a 3 percent annual increase in its Title IV-E allocation. Florida negotiated these terms with ACF using analysis of historical trends in Title IV-E expenditures. Florida's waiver authority was originally set to expire in October 2011. ACF has extended Florida's waiver authority through March of 2013 under the same terms and conditions as the original waiver. Florida has applied for renewal of its waiver, and if the waiver is renewed, its Title IV-E allocation will be renegotiated.

[46]Vargo et al., *IV-E Waiver Demonstration Evaluation Final Evaluation Report SFY 11-12*, a Title IV-E waiver evaluation submitted to the Florida Department of Children and Families, March 15, 2012.

these placement expenditures.[47] According to Virginia officials, Title IV-E funding restrictions such as these seem misaligned with federal policy principles and fail to create incentives for states to invest in services designed to prevent foster care placement. In New Mexico, a state official said that increased Title IV-E flexibility would allow them to expand investments in services that prevent foster care placement. At the same time, another state official said that Title IV-E funds were an important source of guaranteed support for children in foster care, and cautioned that New Mexico may have difficulty ensuring that adequate resources are devoted to those children if Title IV-E funds are used for different purposes. Some experts and policymakers have also suggested reforms to how child welfare services are funded and have put forth proposals that would change the way states can use Title IV-E funding. These proposals include instituting various mechanisms for allowing states to increase their focus on services that aim to keep families together while also preserving adequate funding for those children who must be placed in foster care.

[47]In 2006, GAO reported that Title IV-E administrative expenditures grew by $173 million between 2000 and 2004, largely due to increased foster care placement costs. According to this report, an ACF official reported that some states claimed placement costs for foster care candidates more aggressively than others. In 2005, HHS's Office of Inspector General and ACF regional staff recommended large disallowances in costs claimed by Virginia for foster care candidates. Specifically, HHS denied $28 million of Virginia's Title IV-E claims for 8 quarters in fiscal years 2003 through 2005 for absence of a methodology for allocating costs, charging unallowable activities, failure to demonstrate that the children were eligible, and other problems with documentation. GAO, *Foster Care and Adoption Assistance: Federal Oversight Needed to Safeguard Funds and Ensure Consistent Support for States' Administrative Costs*, GAO-06-649 (Washington, D.C.: June 15, 2006).

Child Welfare Agencies Have Difficulty Securing Many Services Due to a Variety of Challenges

Gaps in Child Welfare Services Include Substance Abuse and Mental Health Services

Data from a national survey conducted by ACF indicate that not all children and families in the child welfare system receive the services they need. The survey included interviews with a sample of over 5,000 children and caregivers with child protective investigations closed between February 2008 and April 2009. Many of these children and caregivers reported that they had not received services for which they had a demonstrated need in the 12 months prior to being interviewed.[48] For instance, an estimated 91 percent of caregivers who needed substance abuse services had not received them (see table 3). Additionally, an estimated 58 percent of younger children and 48 percent of adolescents at risk for behavioral, emotional, or substance abuse problems had not received any behavioral health services during this same time period.[49]

[48]Service need was determined by a combination of objective measures, caseworker observations, and self-reported need. Standard errors used to calculate confidence intervals were provided by ACF and were not calculated by GAO. Additionally, because child and caregiver interviews took place about 4 months, on average, after the child welfare investigation had concluded, data on services received within the past 12 months may include services obtained prior to the family's involvement with the child welfare system.

[49]Past GAO work corroborates these findings. In a 2006 GAO survey of 50 state child welfare directors, most directors expressed dissatisfaction with the level of mental health and substance abuse services provided to parents and children and with the adequacy of transportation and housing services for parents. GAO, *Child Welfare: Improving Social Service Program, Training, and Technical Assistance would Help Address Long-standing Service-Level and Workforce Challenges,* GAO-07-75 (Washington, D.C.: Oct. 6, 2006).

Table 3: Percent of Caregivers and Children with Selected Service Needs Who Reported They Had Not Received Related Services in the Past 12 Months: 2008-2009

Service need	Percent of individuals not receiving needed service in past 12 months	95 percent confidence interval
Caregivers		
Substance abuse services	91	88 – 95
Domestic violence services	88	84 – 92
Mental health services	48	43 – 53
Children		
Individualized Family Service Plan or Individualized Education Program to address developmental problems in children 5 and under	87	82 – 92
Behavioral health services (1.5- to 10-year-olds)	58	50 – 65
Behavioral health services (11- to 17-year-olds)	48	40 – 56

Sources: H. Ringeisen et al., *NSCAW II Baseline Report: Caregiver Health and Services,* OPRE Report #2011-27d (Washington, D.C.: 2011). H. Ringeisen et al., *NSCAW II Baseline Report: Children's Services*, OPRE Report#2011-27f. (Washington, D.C.: 2011)

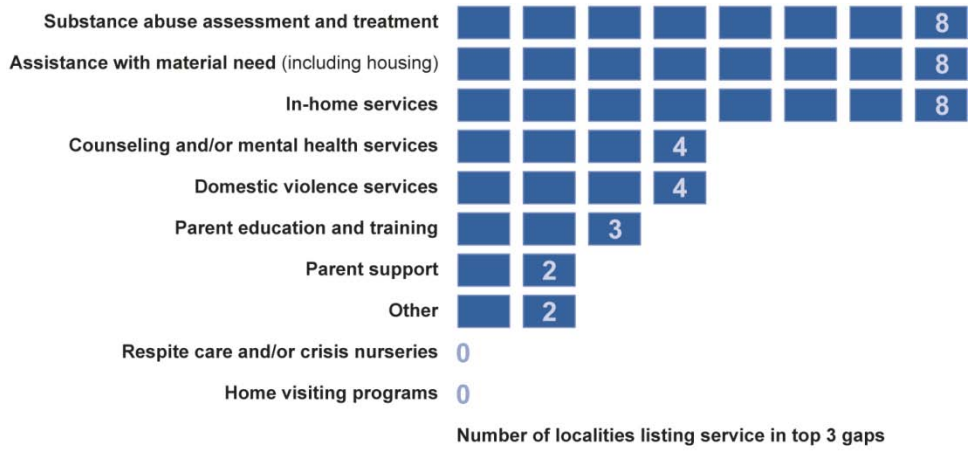
ACF reviews of state child welfare systems also suggest that children and families may not receive the services they need. ACF's most recent Child and Family Services Reviews, conducted from fiscal years 2007 to 2010, showed that 20 of 52 states did not have an appropriate range of services to adequately identify and address the needs of children and families.[50] ACF defined an appropriate range of services as those that help create a safe home environment and enable children to remain at home when reasonable, and help find other permanent homes for foster and adopted children. ACF officials told us that, while the reviews do not include formal data on the availability of specific services, their reports on individual states indicate that the most commonly unavailable services included: behavioral health services, including child psychologists and psychiatrists; substance abuse treatment for adults and youth; housing; and domestic violence services. In a survey funded by Casey Family Programs, 25 out of 41 of state child welfare agencies responding reported waiting lists for

[50]The District of Columbia and Puerto Rico were treated as states for the purposes of these reviews.

at least one service provided by child welfare agencies or their purchased service providers.[51] (This survey did not ask states about the length of time a child or family remained on the waiting list before receiving services.) These services included in-home services, home visiting services, and substance abuse assessment and treatment. The absence of a waiting list, however, does not necessarily indicate that services are available. A service provider may not maintain a waiting list even if there are families waiting to be served.

Officials from our 13 selected localities echoed these concerns. In response to a GAO data collection instrument, most of these localities reported key service gaps in the areas of substance abuse assessment and treatment services; assistance with material needs, such as housing and transportation; and in-home services (see figure 4).

Figure 4: Top Child Welfare Service Gaps Reported by 13 Selected Localities (3 Selections per Locality)



Source: GAO analysis of information provided by child welfare officials in 13 selected localities.

Note: The "other" service gaps reported were inadequate public transportation infrastructure and lack of Medicaid-participating medical, dental, and behavioral health service providers. Respondents were asked to choose the top three service gaps in their area. Thus, localities may have also experienced service gaps in other areas not selected. Additionally, this data collection instrument did not ask local officials to identify gaps related to service quality. In particular, it did not ask whether available services incorporated evidence-based or evidence-informed practices.

[51]The District of Columbia and Puerto Rico were treated as states for the purposes of this survey. K. DeVooght et al., *The 2011 Casey Family Programs State Prevention Policy Survey: A Patchwork of Policies and Programs to Prevent Child Maltreatment*. (Washington, D.C.: Casey Family Programs, June 2012).

Gaps in Services May Lead to Poorer Outcomes for Children and their Families

Service gaps can negatively affect outcomes for children and their families. Specifically, according to officials in our 13 selected localities, previous GAO work, and some research, service gaps can complicate efforts to prevent placement in foster care, hinder chances of reunification after foster care, and harm child well-being.

Officials in our selected localities reported that difficulty securing high-quality, timely treatment for families with parental substance abuse problems can decrease the likelihood of recovery and reunification.[52] In 6 of 13 selected localities, officials reported waiting lists for substance abuse treatment services. Officials in one of these localities noted that clients often wait 2 to 3 months for these services.[53] Further, officials in five localities said that available inpatient services were of poor quality or too short in duration to meet client needs. New Mexico officials told us their state's behavioral health entity covered a maximum of 30 days of inpatient substance abuse treatment, which they said is insufficient for long-term addicts.

Some research corroborates the views of local officials that lack of access to timely, intensive treatment may negatively affect a family's chances of reunification. A 2007 study of nearly 2,000 women in Oregon who were substance abusers and had children in foster care found that mothers were more likely to be reunited with their children if they entered treatment quickly and spent more time in treatment.[54] Similarly, in California, a study of more than a thousand mothers who participated in a drug treatment program in 2000 found that mothers who completed or

[52]HHS has estimated that between one- and two-thirds of children in the child welfare system have at least one parent with a substance abuse problem. See The Department of Health and Human Services, *Blending Perspectives and Building Common Ground* (Washington, D.C.: April 1999). In addition, researchers at Chapin Hall at the University of Chicago drew upon NSCAW data from 2000 to estimate that 61 percent of infants and 41 percent of older children placed in foster care had at least one caregiver affected by substance abuse. See F. Wulczyn, M. Ernst, and P. Fisher, "Who Are the Infants in Out-of-Home Care? An Epidemiological and Developmental Snapshot," *Chapin Hall Issue Brief* (May 2011).

[53]Officials in six localities also reported wait times for counseling or mental health services. In five of these localities, officials reported that wait times were 2 to 3 months or longer.

[54]B.L. Green, A. Rockhill, and C. Furrer, "Does Substance Abuse Treatment Make a Difference for Child Welfare Case Outcomes? A Statewide Longitudinal Analysis." *Children and Youth Services Review,* vol. 29 (2007).

spent at least 90 days in treatment were about twice as likely to reunify with their children as those who spent less time in treatment.[55] GAO previously reported on family-centered residential drug treatment programs, which can last up to 24 months and may allow women to bring their children with them. These programs help women address issues underlying their substance abuse, build coping strategies, and enhance parenting skills, which can reduce chances that children will need to be removed to foster care. The Substance Abuse and Mental Health Services Administration (SAMHSA) evaluated performance data from residential treatment programs for mothers and found that 6 months after treatment ended, fewer children of participating women were living in foster care and most children who accompanied their mothers to treatment were still living with them.[56]

Officials in several of our selected localities also said it could be difficult for families experiencing substance abuse to achieve reunification within mandated deadlines.[57] Delays in receiving treatment can make it difficult for treatment to be completed within these deadlines. In addition, a previous GAO report found that mandated reunification deadlines can conflict with the amount of time required to successfully address the needs of these families.[58] One ACF official told us that timely access to high-quality, evidence-based treatment is essential to achieving reunification within mandated timelines. Officials in one selected locality said they frequently terminate parental rights due to parents' inability to establish sobriety within limited time frames. However, officials in another locality reported that judges are sympathetic to substance-abusing

[55]C.E. Grella et al., "Do Drug Treatment Services Predict Reunification Outcomes of Mothers and Their Children in Child Welfare?" *Journal of Substance Abuse Treatment,* vol. 36, no. 3 (2009).

[56]Although these findings suggest positive outcomes of such programs, the SAMHSA study was not designed to demonstrate that the treatment caused those effects. GAO, *Child Welfare: More Information and Collaboration Could Promote Ties Between Foster Care Children and Their Incarcerated Parents,* GAO-11-863 (Washington, D.C.: Sept. 26, 2011).

[57]Under Title IV-E, states must file a petition to terminate parental rights, with certain exceptions, when a child has been in foster care for 15 of the most recent 22 months, and some states begin this process after less than 15 months in foster care. 42 U.S.C. § 675(5)(E).

[58]GAO-11-863.

parents' efforts to engage in services, and frequently extend their permanency deadlines.[59]

According to past GAO work and officials in selected localities, lack of affordable housing may also contribute to children's removal into foster care or may prevent families from reunifying. In 2007, GAO surveyed 48 state child welfare directors about African American children in foster care. Officials from 25 states cited a lack of affordable housing options as one factor that contributed to disproportionately high rates of foster care placement among African American children in the child welfare system. This report found that affordable public housing is a critical support that can help low-income families stay together.[60] Similarly, officials in 3 of our 13 selected localities told us that a parent's inability to obtain housing could prevent family reunification even if all other reunification criteria had been met.[61] However, officials in one locality said they work with families to find them appropriate housing and would not keep a child from his or her parents based solely on the family's housing situation.

GAO previously reported that failure to provide services to address the trauma of abuse or neglect may negatively affect children's well-being in both the short and long term. GAO reported that children may experience traumatic stress as a result of maltreatment, which significantly increases their risk of mental health problems, difficulties with social relationships and behavior, physical illness, and poor school performance. Early detection and treatment of childhood mental health conditions can improve children's symptoms and reduce the likelihood of negative future outcomes, such as dropping out of school or becoming involved in the juvenile justice system.[62] ACF has also made the social and emotional

[59]Similarly, in 2002 GAO found that judges in some states would not necessarily pursue terminating parental rights within these timeframes if a parent was engaged in substance abuse treatment and making progress toward reunification. GAO, *Foster Care: Recent Legislation Helps States Focus on Finding Permanent Homes for Children, but Long-Standing Barriers Remain,* GAO-02-585 (Washington, D.C.: June 28, 2002).

[60]GAO, *African American Children in Foster Care: Additional HHS Assistance Needed to Help States Reduce the Proportion in Care,* GAO-07-816 (Washington, D.C.: July 11, 2007).

[61]An ACF official said that a review of the agency's Child and Family Services Reviews indicated that stakeholders in some localities reported Section 8 waiting lists were a barrier to reunification. However, those barriers were not the main reason for state noncompliance with child welfare standards.

[62]GAO-13-15.

well-being of children receiving child welfare services an agency priority, and is encouraging child welfare agencies to focus on improving behavioral and social-emotional outcomes for the children they serve.[63]

In Our Selected Localities, Service Gaps Were Caused by Factors Including Provider Shortages and Challenges Accessing Services of Partner Agencies

Provider Shortages

Officials from 8 of our 13 selected localities reported a shortage of substance abuse treatment providers. Some officials cited a shortage of treatment in general, while others discussed shortages of specific kinds of treatment. For instance, officials from six localities reported an inadequate number of inpatient treatment providers. Officials from two selected localities also reported particular difficulty finding providers that offered appropriate substance abuse treatment services for adolescents. In one Virginia locality with extremely high rates of substance abuse, officials said that in order to address this shortage, their local behavioral health agency had hired a counselor dedicated to treating youth with substance abuse problems. However, this counselor served five counties and had difficulty keeping up with demand.

Officials from nine selected localities as well as three state officials from our discussion group reported a shortage of mental health service providers. Officials from six localities and three state officials from our discussion group also noted shortages of certain types of specialists. For example, officials from multiple localities in three out of four selected

[63]ACF, *Information Memorandum: Promoting Social and Emotional Well-Being*.

states reported acute shortages of child psychiatrists.[64] One state official who participated in our discussion group also reported particular difficulty finding mental health providers who offered evidence-based therapies specifically designed to address trauma in children. Officials in one Florida locality said that service providers in their community were interested in becoming trained in certain evidence-based practices, but found it too costly to do so. To address mental health provider shortages, Minnesota's Department of Human Services contracted with the Mayo Clinic to provide phone-based psychiatric consultation services to primary care doctors across the state. Officials said the initiative would improve the quality of psychiatric care for children, including children in the child welfare system.

Officials in several localities across three states and from one state in our discussion group reported a shortage of mental health, substance abuse, and/or other service providers who accept Medicaid. GAO has previously reported on this issue. In a recent survey of states, GAO found that 17 states reported challenges ensuring enough mental health and substance abuse providers for Medicaid beneficiaries.[65] Additionally, GAO found in 2011 that more than three times as many primary care physicians reported difficulty referring children enrolled in Medicaid or the Children's Health Insurance Program (CHIP) to specialists as compared with privately-insured children.[66]

[64]GAO recently reported that mental health specialists, such as child psychiatrists and psychologists, were the among most difficult specialist referrals to obtain for children. GAO, *Medicaid and CHIP: Most Physicians Serve Covered Children but Have Difficulty Referring Them for Specialty Care,* GAO-11-624 (Washington, DC: June 30, 2011). Additionally, the Institute of Medicine has reported that a shortage of mental health providers is a major factor affecting access to services, especially for children. Institute of Medicine of the National Academies, Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders, *Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series* (Washington, D.C.: 2006).

[65]GAO, *Medicaid: States Made Multiple Program Changes and Beneficiaries Generally Reported Access Comparable to Private Insurance,* GAO-13-55 (Washington, D.C.: Nov. 15, 2012).

[66]CHIP provides federal matching funds to states to provide health coverage to children in low-income families whose incomes exceed the eligibility requirements for Medicaid. These physicians reported that referrals to mental health specialists were among the most difficult to obtain for both children enrolled in Medicaid or CHIP and privately-insured children. GAO-11-624.

Finally, provider shortages were cited as particularly challenging in rural areas. Officials in localities across all four selected states and two state officials from our discussion group reported provider shortages in rural areas. Officials from some rural localities described difficulty attracting and retaining service providers. A local Florida official said that one of his agency's behavioral health purchased service providers had been advertising a child psychiatrist position for 5 years without success. In several localities, officials said provider shortages often result in families traveling long distances to receive services in more urban areas.

Lack of Health Insurance

Inadequate health coverage among some children and families in the child welfare system also contributes to service gaps. In 6 of 13 localities, officials cited lack of health insurance as a factor contributing to difficulty securing medical services for families. Officials from selected localities reported that in some cases services were more difficult to obtain for parents than for their children, due to lack of health insurance.[67] In addition, undocumented immigrants are not eligible for Medicaid and may lack private health insurance as well. Officials in several localities described particular difficulty obtaining services for these families. There are, however, a variety of approaches local officials reported using in order to obtain services for families. In some cases, agencies were able to turn to behavioral health agencies. And in one locality, officials said a local non-profit sometimes funded mental health assessments for clients without insurance. In other cases, officials said their agencies paid for these services with their own funds. Additionally, fewer parents in the child welfare system may lack health insurance after January 1, 2014, when states may expand eligibility for Medicaid coverage to non-elderly non-pregnant adults with incomes at or below 133 percent of the federal

[67]Under federal law, states are currently required, at a minimum, to extend Medicaid eligibility to children up to 6 years of age in families with income at or below 133 percent of the federal poverty level. States also must cover children from 6 to 19 in families with income at or below 100 percent of the federal poverty level under Medicaid and must extend this coverage up to 133 percent of the federal poverty level no later than January 2014. Under CHIP, states may cover children in families with higher income levels who are ineligible for Medicaid and do not have access to other insurance. For parents, however, mandatory coverage generally is more limited under Medicaid. States must, at a minimum, cover parents who meet the state's 1996 Aid to Families with Dependent Children eligibility criteria. In addition, some states have expanded eligibility to cover additional parents through other eligibility paths available in the Medicaid program.

poverty level, as provided for under the Patient Protection and Affordable Care Act.[68]

Inadequate Transportation

Lack of transportation is also a widespread impediment to obtaining services, especially in rural areas. Officials in all selected agencies that served rural areas reported difficulty with transportation for rural clients, and discussion group participants from two additional states reported similar difficulties. A number of local officials said that providing services in the home could help mitigate transportation challenges, as well as allow providers to better assess and address challenges in the home environment. Some officials noted that in-home services are typically more expensive than office-based services. However, officials in one Florida locality reported that they had made in-home services a budgetary priority due to transportation challenges in their area.

Limited Funding for Preventive Services

While state child welfare agencies receive reimbursement under Title IV-E for many costs related to children in foster care, funding for services designed to prevent the need to remove children from their homes and place them in foster care is more limited. State and local child welfare agencies may face difficult decisions when determining which of these prevention activities to prioritize and fund, particularly in light of the ongoing fiscal challenges states face. For instance, local officials in New Mexico described challenges in securing resources to provide services to children and families at risk of foster care placement. New Mexico state officials told us they contracted for services designed to avoid foster care placement or reunite families after foster care entirely with Title IV-B PSSF family preservation and reunification funds and did not allocate state or other federal funds to support these contracts. Because Title IV-B funds were limited, the state targeted services only to selected counties with the highest need. Officials in one New Mexico county said that most of their family preservation and reunification services were cut for fiscal year 2013, in part because they had been successful in reducing the number of children in foster care and were no longer considered a high need county.

[68]Pub. L. No. 111-148, § 2001, 124 Stat. 119, 271 (2010) (PPACA), as amended by the Health Care and Education Reconciliation Act, Pub. L. No. 111-152, 124 Stat. 1029 (2010). PPACA also provides for a 5 percent income disregard when calculating modified adjusted gross income for determining Medicaid eligibility, which effectively increases this income level to 138 percent of the federal poverty level.

Fiscal challenges have also affected child welfare partner agencies. For example, one ACF official we interviewed noted that most states have experienced budget cuts in social services, which affect both child welfare and substance abuse services. In addition, officials from SAMHSA told us that since 2008, states have had more difficulty maintaining state funding of behavioral health services.

Challenges Accessing Services from Partner Agencies

Many localities experienced gaps in services provided by partner agencies, in some cases due to the fiscal constraints of those agencies. For example:

- Officials in 7 of the 13 localities, as well as one state official from our discussion group, said that their local housing authorities had long waiting lists (in some cases up to 3 or 4 years) for Section 8 housing vouchers.[69] As a result, families referred to the housing authority often did not receive assistance.

- In a few localities, officials said that families with children in foster care could not obtain approval for public housing units until they had regained custody, which hindered efforts to reunite children with their families.[70] One ACF official said that, in response to GAO's inquiry, the agency initiated discussions with HUD about improving outreach to local housing authorities about this issue.

- Officials in two localities in different states, as well as one state official from our discussion group, noted that their state Medicaid programs required diagnoses of mental health disorders to cover services, even for very young children (ages 0 to 3 years). Officials stated that these requirements could make obtaining needed services difficult in some cases, and could result in inappropriate diagnoses in other cases.[71]

[69]Section 8, also known as the housing choice voucher program, is the federal government's major program for assisting very low-income families, the elderly, and the disabled to afford housing in the private market. Housing choice vouchers are administered locally by public housing agencies, which receive federal funds from HUD.

[70]HUD regulations stipulate that public housing authorities should include children who are temporarily away from the home because of placement in foster care when determining a family's size for Section 8 housing purposes. 24 C.F.R. §§ 982.402(b)(4) and 945.303(e).

[71]States may place appropriate limits on accessing services based on medical necessity or utilization control procedures. 42 C.F.R. § 440.230.

However, in some cases, selected child welfare agencies coordinated with other service agencies to improve families' access to services. For example:

- Three selected localities had coordinated with their local housing authority to apply for a grant through the federal Family Unification Program, which sets aside housing vouchers for families in the child welfare system.

- Two selected localities had Family Dependency Treatment Courts, which coordinate court, treatment, and child welfare services for child welfare cases in which parental substance abuse is a primary factor.

- One Virginia locality collaborated with partner agencies to use funding provided under the American Reinvestment and Recovery Act for homelessness prevention and rapid re-housing to help families at risk of eviction.[72] As these funds were about to expire, they worked with community partners to identify other sources of funding to allow this homelessness prevention program to continue.

There are also other opportunities on the federal, state, and local level for child welfare and partner agencies to coordinate to improve service delivery for children and families in the child welfare system. For instance:

- ACF awards regional partnership grants for projects designed to increase the well-being of, and improve the permanency outcomes for, children affected by substance abuse through interagency collaboration and program and service integration. In 2012, ACF awarded 17 new regional partnership grants and approved 2-year extensions for 8 of 53 grants awarded in 2007.

- In September 2012, ACF awarded five grants totaling $25 million for collaborative partnerships between child welfare agencies and housing/ shelter organizations. Grants were awarded to projects focused on improving safety, family functioning, and child well-being in families at risk of homelessness and child maltreatment.[73]

[72]Pub. L. No. 111-5, 123 Stat. 115, 221 (2009).

[73]Private foundations have committed to funding technical assistance and project evaluations.

- Also in 2012, ACF awarded nine grants totaling almost $29 million over 5 years for projects to improve the social and emotional well-being of children and youth in the child welfare system. The purposes of these grants, which are in the form of cooperative agreements, include improving adoption outcomes through interagency collaboration and supporting child welfare agencies in assessing children's mental and behavioral health needs.

- The Commissioner of ACF's Administration on Children, Youth and Families told us the agency is encouraging states to collaborate with state Medicaid agencies to solve issues affecting families in the child welfare system, including barriers to accessing Medicaid-funded mental health services for infants. As an example, he said ACF's most recent Title IV-E waiver announcement encouraged state child welfare agencies to submit proposals in conjunction with state Medicaid agencies. According to the Commissioner, six out of nine approved waiver proposals explicitly indicate a partnership with the state Medicaid agency.

- In fiscal year 2012, SAMHSA awarded 16 grants totaling almost $16 million to implement systems of care (which involve collaboration across government and private agencies, providers, and families) for children and youth with serious emotional disturbances. According to agency officials, 14 grantees were coordinating with child welfare agencies to address service development, funding, and access to care for children and youth in the child welfare system and those at risk of abuse or neglect.

Concluding Observations

Child welfare agencies, like other state agencies, operate in an environment of ongoing fiscal constraint. They must make difficult choices about how to allocate their limited resources to support services critical to ensuring children's safety and well-being. Despite their use of Title IV-B funding in combination with other federal dollars to supplement their state and local funds, these agencies continue to struggle to meet the complex needs of children not in foster care and their families. Given current state and federal fiscal constraints, they will likely continue to struggle. The waivers HHS has granted to some states to use their Title IV-E funding more flexibly may provide useful information about the effects of shifting available resources from foster care costs to support services intended to reduce the need for foster care without increasing funding overall.

Agency Comments and Our Evaluation

We provided a draft of this report to the Secretary of Health and Human Services for review and comment. HHS indicated in its general comments, reproduced in appendix I, that it agreed with GAO's finding that gaps exist in services to address the effects of child maltreatment, and provided additional information about the agency's emphasis on trauma-informed care and its efforts to encourage child welfare agencies to respond more effectively to trauma. The agency also agreed with GAO's concluding observations that ongoing fiscal constraints contribute to challenges in meeting the needs of children and families, and offered two steps child welfare agencies could take to more effectively use available resources: (1) identify currently funded services that do not yield desired results and shift resources toward evidence-based programs and practices; and (2) use outcomes (specifically those related to child well-being), rather than services delivered, to measure program success. Our report did not address the effectiveness of specific services; however we agree that information about effective practices is an important tool that child welfare agencies can use to determine how best to allocate available funds. Additionally, our work has long shown that using outcomes is an important component of measuring program success.[74]

HHS also discussed the use of TANF funds for child welfare purposes in its comments, and noted that in addition to the services described in our report, TANF funds are spent on foster care maintenance payments and adoption subsidies, as well as relative foster care maintenance payments and guardianship subsidies. Because this report focuses on expenditures for services typically covered under Title IV-B, we did not include maintenance payments and adoption subsidies in the scope of our review. We have clarified that, due to the similarity among these payment types, we excluded relative maintenance payments and guardianship subsidies as well. HHS also noted that states may spend federal TANF funds on purposes authorized solely under prior law that do not meet a TANF purpose, and that many of these expenditures are for child welfare purposes. We have also clarified that our analysis includes these expenditures, as appropriate. Finally, HHS described planned revisions to its TANF expenditure reporting form to capture more detailed information about how states spend TANF funds on child welfare payments and services. We have not reviewed these plans; however, we recently

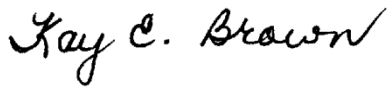
[74]GAO, *Agency Performance Plans: Examples of Practices That Can Improve Usefulness to Decisionmakers,* GAO/GGD/AIMD-99-69 (Washington, D.C.: February 26, 1999).

recommended that HHS develop a detailed plan and specific timelines to help monitor its progress in revising these TANF reporting categories.[75]

In addition to these general comments, HHS also provided us with technical comments that we incorporated, as appropriate.

We are sending copies of this report to relevant congressional committees, the Secretary of Health and Human Services, and other interested parties. In addition, this report will be available at no charge on GAO's website at http://www.gao.gov.

If you or your staffs have any questions about this report, please contact me at (202) 512-7215 or brownke@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff that made key contributions to this report are listed in appendix II.



Kay E. Brown
Director
Education, Workforce
and Income Security Issues

[75]GAO-13-33

Appendix I: Comments from the Department of Health and Human Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF THE SECRETARY

Assistant Secretary for Legislation
Washington, DC 20201

JAN 2 2 2013

Kay E. Brown
Education, Workforce, and
Income Security Issues
U.S. Government Accountability Office
441 G Street NW
Washington, DC 20548

Dear Ms. Brown:

Attached are comments on the U.S. Government Accountability Office's (GAO) report entitled, CHILD WELFARE: "States Use Flexible Federal Funds, But Struggle to Meet Service Needs" (GAO-13-170).

The Department appreciates the opportunity to review this report prior to publication.

Sincerely,

Jim R. Esquea
Assistant Secretary for Legislation

Attachment

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S (GAO) DRAFT REPORT ENTITLED, "CHILD WELFARE: STATES USE FLEXIBLE FEDERAL FUNDS, BUT STRUGGLE TO MEET SERVICE NEEDS" (GAO-13-170)

The Department appreciates the opportunity to review and comment on this draft report.

Historically, federal policies have impelled child welfare systems to focus disproportionately on ensuring safety and permanency for the children they serve, with less emphasis on promoting well-being. HHS concurs with GAO's findings that reflect the inadequate attention that has been paid to the consequences of maltreatment. HHS has made a concerted effort to shift to policies and practices that support child welfare agencies to more fully integrate safety, permanency, and well-being to better serve children and families.

HHS's focus on preventing and treating early exposure to trauma, including child maltreatment, is grounded firmly in the science about its devastating impact on lifelong well-being. Researchers have extensively documented the impacts of abuse and neglect on the short- and long-term health and well-being of children. These impacts can hinder children's development into healthy, caring, and productive adults and keep them from reaching their full potential. Many of the children involved with child welfare have a set of complex challenges; these challenges may not be addressed by the system and services as they are currently designed.

Although we agree with the GAO's concluding observations, we believe that child welfare systems can reorganize their current funding streams to provide more effective services than those they are currently providing. A careful analysis of the way the child welfare system is currently structured and the systemic changes that are necessary to promote social and emotional well-being should include:

1. **A Program Inventory:** Examine current spending to understand where resources can be shifted to support evidence-based programs and practices. Many states are currently purchasing services that are not reliably yielding the desired results, such as generic counseling, parenting classes, and life skills training for emancipating youth. By identifying resources that are being used to support these types of services, child welfare systems can begin planning to de-scale them and repurpose funds for evidence-based interventions. Ideally, administrators will combine this work with an analysis of data describing the needs of the population of children receiving child welfare services in order to identify areas in which de-scaling and installation of new practices can improve child and family outcomes.

2. **Measuring Outcomes, Not Services:** It is common for child welfare systems to gauge their success based on whether or not services are being delivered. One way to focus attention on well-being is to measure how young people are doing behaviorally, socially, and emotionally and track whether or not they are improving in these areas as they receive services. At the system level, data from trauma screenings and functional assessments can help administrators understand how successful their child welfare systems are in achieving positive outcomes for children and youth. This understanding can inform decisions about the array of services that are currently available and the procurement of services going forward.

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S (GAO) DRAFT REPORT ENTITLED, "CHILD WELFARE: STATES USE FLEXIBLE FEDERAL FUNDS, BUT STRUGGLE TO MEET SERVICE NEEDS" (GAO-13-170)

We acknowledge that reorganizing a child welfare system to respond more effectively to the traumatic impact of maltreatment and promote social and emotional well-being is complex work. Multiple, complementary strategies must be employed in order to create systematic changes that improve outcomes for children. In order to support this difficult task, HHS has been deliberate in aligning much of its discretionary funding as well as its new title IV-E child welfare demonstration authority to (1) increase the capacity of the workforce to meet the needs of children and families; (2) support caregivers so they can provide children with environments and relationships that offer security and developmental support; (3) offer targeted supports that help children build coping skills and social skills; and (4) enhance access to screening, assessment, and effective intervention. These projects have a specific focus on addressing trauma and improving the well-being of children, youth, and families. Across federal agencies, preventing trauma and mitigating its impact on healthy development is a growing priority. In much of its work, ACF has partnered with the Centers for Medicare & Medicaid Services (CMS) and the Substance Abuse and Mental Health Services Administration (SAMHSA) to align and strengthen efforts; CMS and SAMHSA are engaged in several of the ACF supported projects.

As child welfare systems continue to improve and refine their work to promote safety and permanency for children, a strengthened focus on the social and emotional well-being of children who have experienced maltreatment is the logical next step in reforming the child welfare system. Children who have been abused or neglected have significant social-emotional, behavioral, and mental health challenges requiring attention, and treating them with a trauma-focused and evidence-based approach can improve outcomes throughout child welfare. This approach can result in increased placement stability; greater rates of permanency through reunification, adoption, and guardianship; and greater readiness for successful adulthood among all children who exit foster care, especially those youth who leave foster care without a permanent home. Most importantly, it will enable children who have experienced maltreatment to look forward to bright, healthy futures.

Further, HHS would like to note the Administration has proposed in the FY 2013 budget to include $2.5 billion over 10 years in mandatory funds to support program improvements based on the following principles:

- Creating financial incentives to improve child outcomes in key areas, by reducing the length of stay in foster care, increasing permanency through reunification, adoption, and guardianship, decreasing rates of maltreatment recurrence and any maltreatment while in foster care, and reducing rates of reentry into foster care;
- Improving the well-being of children and youth in the foster care system, transitioning to permanent homes, or transitioning to adulthood, to include:
  - Ensuring proper oversight and monitoring for psychotropic medications;
  - Providing appropriate therapeutic services using the best research available on effective interventions;
  - Building capacity in child welfare and mental health systems to ensure effective interventions are available; and

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S (GAO) DRAFT REPORT ENTITLED, "CHILD WELFARE: STATES USE FLEXIBLE FEDERAL FUNDS, BUT STRUGGLE TO MEET SERVICE NEEDS" (GAO-13-170)

- Training child welfare staff and clinicians to provide effective, evidence-based interventions that address the trauma and mental health needs of children in foster care.
- Reducing costly and unnecessary administrative requirements, while retaining the focus on children in need.

While the report largely focuses on TANF funded non-assistance child welfare services, it is also worth noting that states also use TANF to fund child welfare benefits that constitute assistance, as per definition at 45 CFR 260.31. These include relative foster care maintenance payments (basic assistance provided on behalf of a child [or children] for whom the child welfare agency has legal placement and care responsibility and is living with a caretaker relative who is not eligible for IV-E foster care assistance), and adoption and guardianship subsidies (basic assistance provided on behalf of a child [or children] for whom the child welfare agency has legal placement and care responsibility and is living with adoptive parents or legal guardians who are not eligible for IV-E adoption or guardianship subsidies). For example, Florida, one of the selected states, has a relative caregiver program that provides assistance to relative caregivers when children have been placed with the relative by the court as part of a dependency action.

Additionally, states may spend federal TANF funds on assistance and non-assistance authorized solely under prior law, which do not meet a TANF purpose, but are allowed pursuant to Section 404(a)(2) of the Social Security Act, which permits states to use TANF – but not MOE – funds in any manner that was allowed under the prior title IV-A (AFDC) or IV-F (Job Opportunities and Basic Skills Training Program) on September 30, 1995, or at state option, August 21, 1996. Additional reporting authorized by the Claims Resolution Act of 2010 (CRA) revealed that child welfare activities, such as foster care payments and services, comprised 85 percent of assistance and non-assistance authorized solely under prior law for the April-June quarter of fiscal year (FY) 2011. Although CRA reporting captured actual expenditures for this quarter only, assistance and non-assistance authorized solely under prior law comprised 9.2 percent of total federal TANF expenditures (including transfers) in FY 2011.

HHS's expenditure data collection does not currently include separate categories for child welfare non-assistance activities, relative foster care maintenance payments, adoption and guardianship subsidies, and child welfare assistance and non-assistance authorized solely under prior law. We are currently in the process of revising the ACF-196 to better capture these types of expenditures. This will shed light on the extent to which TANF and MOE are being used to fund such expenditures, as the expenditure data collection authorized by the CRA was limited to March and April-June of 2011 only.

Appendix II: GAO Contact and Staff Acknowledgments

GAO Contact

Kay E. Brown, (202) 512-7215 or brownke@gao.gov

Staff Acknowledgments

In addition to the contact name above, the following staff members made key contributions to this report: Elizabeth Morrison, Assistant Director; Lauren Gilbertson; James Lloyd; Erin McLaughlin; Ellen Phelps Ranen; and Deborah Signer. Also contributing to this report were: Susan Anthony, Jeff Arkin, Carl Barden, James Bennett, Jessica Botsford, David Chrisinger, Kim Frankena, Ashley McCall, Phillip McIntyre, Jean McSween, Almeta Spencer, Hemi Tewarson, James Rebbe, and Carolyn L. Yocom.