A REPORT
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Performance Audit Division

Special Report

Arizona Department of Child Safety—Children Support Services—Emergency and Residential Placements

October • 2014
Report No. 14-107

STATE OF ARIZONA
OFFICE OF THE
AUDITOR GENERAL

Debra K. Davenport
Auditor General

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Marc Owen, Team Leader
Deanna Ahmad
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Office of the Auditor General
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STATE OF ARIZONA
OFFICE OF THE
AUDITOR GENERAL

DEBRA K. DAVENPORT, CPA
AUDITOR GENERAL

MELANIE M. CHESNEY
DEPUTY AUDITOR GENERAL

October 15, 2014

Members of the Arizona Legislature

The Honorable Janice K. Brewer, Governor

Mr. Charles Flanagan, Director
Arizona Department of Child Safety

Transmitted herewith is a report of the Auditor General, *A Special Report of the Arizona Department of Child Safety—Children Support Services—Emergency and Residential Placements*. This report is in response to Laws 2013, 1st S.S., Ch. 10, §33, and was conducted under the authority vested in the Auditor General by Arizona Revised Statutes §41-1279.03. I am also transmitting within this report a copy of the Report Highlights for this audit to provide a quick summary for your convenience.

As outlined in its response, the Arizona Department of Child Safety agrees with the finding and plans to implement all of the recommendations.

My staff and I will be pleased to discuss or clarify items in the report.

Sincerely,

Debbie Davenport
Auditor General

Attachment

2910 NORTH 44th STREET • SUITE 410 • PHOENIX, ARIZONA 85018 • (602) 553-0333 • FAX (602) 553-0051

STATE OF ARIZONA
OFFICE OF THE
AUDITOR GENERAL

Arizona Department of Child Safety—Children Support Services—Emergency and Residential Placements

REPORT HIGHLIGHTS
SPECIAL REPORT

Our Conclusion

The best setting for abused or neglected children who are removed from their homes is a family-based setting, such as with a relative or in licensed foster care. Because it is not family-based, congregate care, such as emergency shelters, group homes, and residential treatment centers, is the least preferred placement option. However, the number of Arizona children and the length of time they are in congregate care has increased and as a result, the costs for this placement type nearly doubled between fiscal years 2009 and 2013. Contributing to the increase in congregate care use is an inadequate supply of foster care homes; various state practices, including some related to permanency goals and activities; and inadequate access to behavioral health services. Although the Arizona Department of Child Safety (Department) has taken some steps to reduce the use of congregate care, it should consider other states' experiences to identify multiple strategies for reducing its use.

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Department should continue taking actions to reduce the use of congregate care

Statute and department policy require that abused or neglected children be placed in the least restrictive, most family-like setting until they are reunified with their parents or other permanent placement is achieved. Generally, congregate care is the least preferred placement because it is the most restrictive and least family-like. Arizona uses three types of congregate care facilities: emergency shelters, group homes, and residential treatment centers.

Congregate care use has increased—The number of children in out-of-home care (with relatives, licensed foster care, or congregate care) increased by approximately 56 percent, from 10,100 children in September 2009 to 15,750 children in March 2014, while the number of children in congregate care increased by approximately 73 percent during this same time—1,259 to 2,176 children. As of September 30, 2013, the typical child in congregate care was a 15-year-old non-Caucasian male who had a clinically diagnosed disability.

The growth in the number of Arizona children in out-of-home care and placed in congregate care is contrary to most states' experience. For example, according to national data, only two other western states, Montana and Nevada, experienced growth in both of their out-of-home and congregate care populations. Additionally, national data indicate that the average percentage of children placed in congregate care for all 50 states, as a percentage of total out-of-home care, decreased slightly, from 13.8 percent in federal fiscal year 2010 to 13.4 percent in federal fiscal year 2012. However, the percentage of Arizona children in congregate care grew from 12.5 percent to 14.2 percent during this same time period.

In Arizona, the percentage of younger children with congregate care as their predominate placement type has also increased from 4.9 percent in calendar year 2009 to 8.4 percent in calendar year 2013. In addition, children who have been placed in congregate care are staying longer.

Finally, not only is congregate care expensive, costing the Department from $40 to $327 per day depending on the placement type, but it may adversely affect the children because it delays permanency and may pose threats to a child's safety and well-being. For example, studies indicate that children who were cared for in congregate care settings were more likely to be arrested, continue problematic behaviors, and have lower levels of education and more substance abuse problems than children cared for in foster homes.

Several factors have increased Arizona's congregate care use:

- **Inadequate supply of foster homes—**Foster homes provide a better setting for children, in part, because they are family settings. However, although the number of Arizona children in out-of-home care increased by 56 percent between September 2009 and March 2014, the number of foster homes has not similarly increased. Specifically, the number of foster homes increased from 3,954 to 4,329 homes during this same time, an increase of 9 percent.
- **Department practices—**Several department practices may be contributing to the

increased use of congregate care. For example, the Department uses independent living and long-term foster care as permanency goals; however, child welfare experts have expressed concerns about these goals because they do not steer children to permanent families. Inadequate permanency planning is another factor that may be contributing to the Department's congregate care use. Although the Department achieved some success by using permanency planning roundtables, which are meetings involving experts intended to achieve permanency for youth, these roundtables were placed on hold. In addition, unsupported assumptions that older children are not adoptable and have unmanageable behavioral issues also tend to create a bias against permanency for older children.

Other practices make successful placements in foster homes less likely, such as providing foster parents with insufficient information about the children. A January 2014 survey of Arizona foster and adoptive parents indicated that 58 percent of respondents felt that they had too little information about the children placed in their homes. Placements are also more successful when transitional activities are planned, such as pre-placement contact and visitation, but such activities are sometimes lacking. Some foster home placements may be poorly matched to the child and not address a child's needs. Further, in January 2014, the Governor's Child Advocate Response Examination Team reported that several systemic department problems may have also contributed to an inappropriate use of congregate care, indicating that the large volume of incoming cases had resulted in heavy caseloads, high staff turnover, insufficient training, and a culture that did not adhere to standard processes.

- **Inadequate access to behavioral health services**—Child welfare experts believe that children with specialized needs can be cared for in a family setting with the right kinds of support. As of September 2013, department data indicated that 31 percent of children aged 13 or older in out-of-home care were clinically diagnosed as emotionally disturbed. Although the Department may place children in therapeutic foster homes to address behavioral health needs, department staff indicated that such homes are designed for only temporary stays. Children whose behavioral health improves in therapeutic homes may be moved to less-restrictive family settings, but require continued support. Foster parents are often frustrated because of the difficulty they face in obtaining needed behavioral health services.

Other jurisdictions have reduced their congregate care use—We reviewed strategies from five other jurisdictions that reduced their congregate care use. For example, Tennessee reduced its congregate care use from 22 percent in January 2001 to 9 percent in January 2009, in part, by requiring providers with congregate care contracts to maintain an array of placement and service options to best meet children's needs. Tennessee paid these providers the same no matter where they placed the child. As a result, providers were incentivized to place children in family-based settings rather than in congregate care because it was less expensive to do so. As of 2009, Tennessee had exceeded its goals by serving 95 percent of all moderately disturbed children and 75 percent of severely disturbed children in family settings.

Department has taken some actions to reduce congregate care use—The Department has worked to improve recruitment and retention of foster parents by partnering with faith-based groups, developing a performance-based contract for foster home recruitment services, and seeking input from children and families in making placement decisions. It has also developed a preliminary plan to redesign its congregate care system. As part of its plan to develop solutions for congregate care, the Department intends to review the best practices of other jurisdictions that have reduced their congregate care use.

Recommendations

The Department should:

- Continue to assess what actions it can take to reduce the number of children entering out-of-home care; and
- Develop and implement a comprehensive approach to reduce the use of congregate care. In doing so, the Department should consider various strategies, such as those used in other jurisdictions, and the reasons for the increased use of congregate care in Arizona.

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INTRODUCTION
Scope and Objectives

The Office of the Auditor General has completed a special report on the use of emergency and residential placements (i.e., congregate care placements) for Arizona children placed in out-of-home care. Specifically, this report evaluates the use of congregate care placements between September 2009 and March 2014 by the former Division of Children, Youth and Families within the Arizona Department of Economic Security, which became the Arizona Department of Child Safety (Department) in May 2014. This report is the third in a series of three reports required by Laws 2013, 1st S.S., Ch. 10, §33, related to expenditures for children support services. As required by law, this report addresses (1) expenditures for congregate care placements (see Finding 1, pages 12 and 13); (2) reasons for the use of these placements, as opposed to foster homes (see Finding 1, pages 12 through 20); and (3) possible methods to reduce the use of these placements in the future (see Finding 1, pages 20 through 25). The first report addressed contracts for foster home recruitment-related services (see Report No. CPS-1301), and the second report addressed transportation services (see Report No. 14-101).

This audit was conducted under the authority vested in the Auditor General by Arizona Revised Statutes (A.R.S.) §41-1279.03.

Congregate care placements

Congregate care is considered least-preferred option for child placement

Congregate care is a placement option for abused or neglected children who are removed from their homes and placed in out-of-home care. Statute and department policy require that children who are removed from their homes be placed in the least restrictive, most family-like setting until they can be reunited with their parents or another permanency goal, such as adoption, is achieved. According to A.R.S. §8-514, the order of preference for placement of children in out-of-home care is (1) with a relative, (2) in licensed foster care, and (3) in a congregate care setting.

Placement decisions are influenced by a variety of factors and may involve several parties, including department staff; the juvenile courts; the Arizona Foster Care Review Board; regional behavioral health authorities (RBHAs) and the behavioral health providers the RHBAs contract with; the child's family, friends, and/or community members; and the child, if appropriate.[1]

According to child welfare experts, congregate care use should be limited in time and to specific circumstances.[2] Congregate care may be an appropriate placement for children in transition from their homes or a prior placement to a family-based setting. It may also be appropriate for children who have medical and/or behavioral needs that require residential treatment. However, experts agree that even these children should ultimately be cared for in a family setting.[3] Achieving permanency for children—defined as family reunification, adoption, or guardianship—is a key goal of child welfare agencies.[4] However, unnecessary or extended placements in congregate care can undermine permanency efforts.[5]

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[1] The Arizona Department of Health Services contracts with RHBAs to administer behavioral health services. Each RBHA contracts with a network of service providers, similar to health plans, to deliver a range of behavioral health services. RBHAs are federally funded to provide behavioral health services to eligible children. According to the Department, most children in out-of-home care are eligible for these federally funded services.

[2] Alpert, L.T., & Meezan, W. (2012). Moving away from congregate care: One state's path to reform and lessons for the field. *Children and Youth Services Review*, 34, 1519-1532.

[3] Annie E. Casey Foundation. (2013). *Reconnecting child development and child welfare: Evolving perspectives on residential placement*. Baltimore, MD: Author; and Feild, T. (2012). *Congregate care rightsizing: What's best for kids is also good for state budgets*. Baltimore, MD: Annie E. Casey Foundation, Child Welfare Strategy Group.

[4] Fruendlich, M., & Avery, R.J. (2005). Planning for permanency for youth in congregate care. *Children and Youth Services Review*, 27, 115-134; and Murphy, A.L., Van Zyl, R., Collins-Camargo, C., & Sullivan, D. (2012). Assessing systemic barriers to permanency achievement for children in out-of-home care: Development of the child permanency barriers scale. *Child Welfare*, 91(5), 37-71.

[5] North American Council on Adoptable Children. (2005). *A family for every child: Strategies to achieve permanence in older foster children and youth* (Family to family: Tools for rebuilding foster care). Baltimore, MD: Annie E. Casey Foundation.

Department uses three types of congregate care settings

There are three types of congregate care facilities available to the Department: emergency shelters, group homes, and residential treatment centers (RTCs). In fiscal year 2013, the Department used congregate care services from 16 shelter providers, 74 group home providers, and 9 RTC providers. Specifically:

- **Emergency shelters—**These facilities receive children for temporary care, 24 hours per day, from placement agencies, law enforcement, parents, guardians, and/or the courts. Shelters vary in the number of children they can house, ranging from as few as 5 children to more than 70 children, but they generally house 15 children or fewer. Some shelters have on-site medical and developmental services for children who require special care. As of March 2014, the daily cost for shelter care ranged from $96 to $200 per bed.

- **Group homes—**These licensed facilities provide 24-hour care and supervision. Group homes typically house five to ten children. Group homes are sometimes used to keep sibling groups together when no foster home is available. Some group homes operate more like foster homes with two "house parents" acting as caregivers. Additionally, some group homes provide behavioral health or therapeutic services; these types of group homes are referred to as behavioral health group homes or therapeutic group homes. As of March 2014, the daily rate for group home care ranged from $40 to $290 per child depending on the level of care provided.

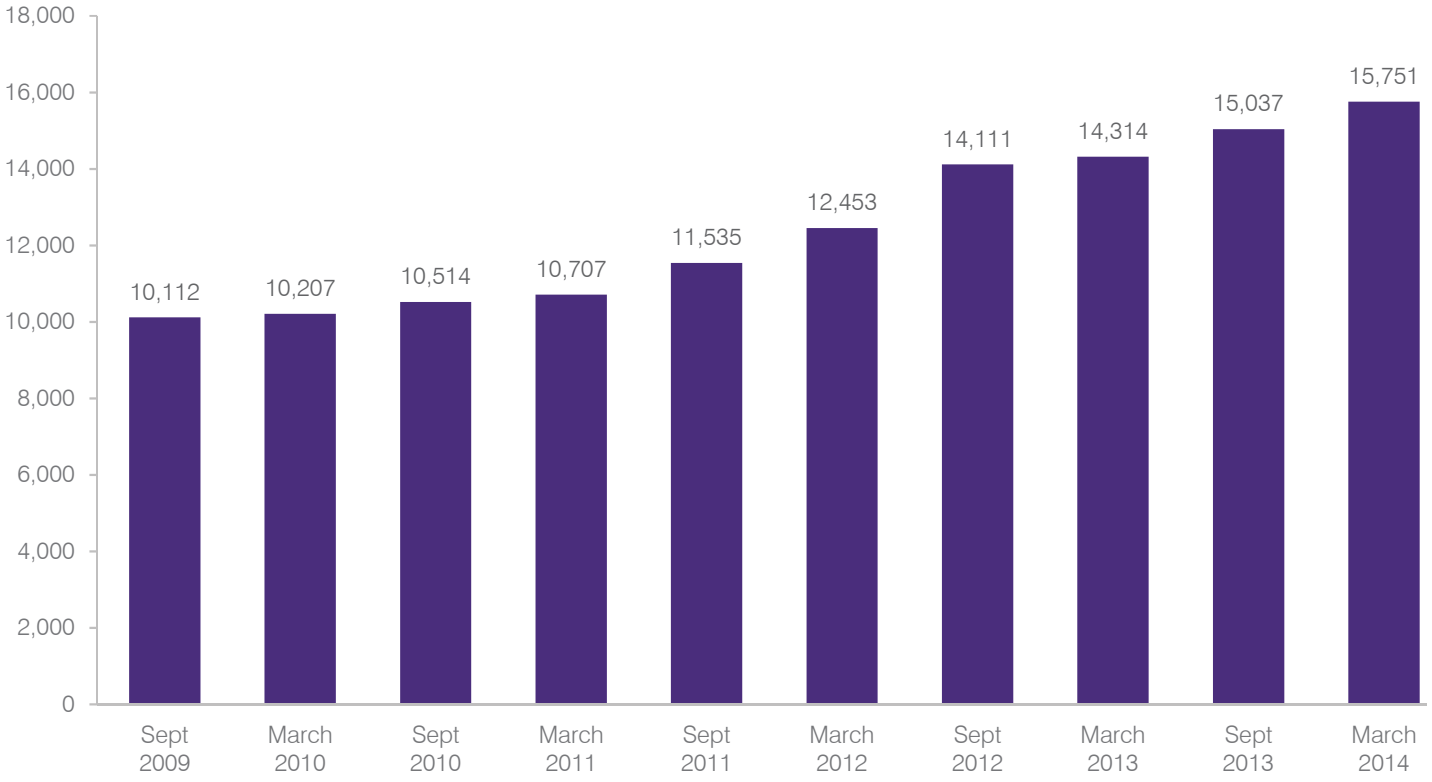
- **RTCs—**These locked or staff-secured facilities provide 24-hour care and supervision and, usually, on-site schooling. RTCs vary in the number of children they house, ranging from 20 to 90 children. RTCs provide intensive care, supervision, and psychiatric oversight of children who have moderate to severe emotional, behavioral, and/or substance abuse problems. Services include individual, group, and family therapy; schooling; recreation; and living skills training. As of March 2014, the daily cost for RTC care ranged from $260 to $327 per child.

Growth in out-of-home care and congregate care

The number of Arizona children placed in out-of-home care—such as with relatives, in licensed foster homes, or in congregate care—grew approximately 56 percent between September 2009 and March 2014, from approximately 10,100 to 15,750 children (see Figure 1, page 3). According to department staff, a variety of factors may have contributed to this increase, including cuts to child abuse and neglect prevention and early intervention services; insufficient staff to meet caseload standards; and the lack of a validated risk and needs assessment tool as well as inconsistent use of the assessment tool that the Department currently uses for making removal decisions. Specifically, funding for prevention and early intervention services was cut starting in fiscal year 2010. These services included the Healthy Families, Intensive Family Services, and Family Builders programs.[1] According to a national expert auditors contacted, cuts to prevention

[1] These programs were created in an effort to prevent child abuse and neglect through offering services to families, including counseling, parenting skills development, and crisis intervention.

Figure 1: Total number of Arizona children in out-of-home care for the 6-month periods ended September 30, 2009 through March 31, 2014



Source: Auditor General staff analysis of information from the Department's semi-annual child welfare reports for the periods ended September 30, 2009 through March 31, 2014.

and early intervention services may increase the likelihood of a child being removed from his/her home. Additionally, the national expert explained that increases in caseloads may result in caseworkers being more likely to remove children from their homes because the caseworkers may have less time to investigate each case, and that the lack of a standardized tool for evaluating the safety of a child's home allows for more subjectivity around removal decisions, which may lead to a higher rate of removal.

Growth in the number of children in out-of-home care has led to an increase in the number of children in all placement types, including congregate care. Specifically, the number of children placed in congregate care settings grew by more than 900 between September 2009 and March 2014, from 1,259 to 2,176 children (see Finding 1, pages 7 through 12, for additional information about growth in the number of children in congregate care). As of September 30, 2013, the typical child in Arizona congregate care was male, about 15 years old, identified with an ethnicity/race other than Caucasian, and had a clinical diagnosis such as mental retardation, a physical disability, or emotional disturbance. As shown in Table 1 (see page 4), children in congregate care are generally older than children in other settings, were older at their first removal, and are more likely to have a diagnosed disability, typically a visual or hearing impairment or emotional disturbance. The textbox on page 5 summarizes the cases of two children in congregate care placements.

Table 1: Demographic information for Arizona children in out-of-home care by placement type As of September 30, 2013

Demographic	Placement type			Total out-of-home care
	With a relative	Licensed foster home	Congregate care	
Median age at first removal	5.0	3.1	10.7	5.0
Median age as of September 30, 2013	5.8	5.6	15.2	7.1
Male children	51%	51%	61%	52%
Clinically diagnosed disability present	29%	45%	60%	43%
Ethnicity/race other than Caucasian	67%	61%	65%	64%

Source: Auditor General staff analysis of Children's Information Library and Data Source data provided by department staff as of September 30, 2013.

Case examples of children in congregate care

Case 1: Jordan was born to two mentally ill parents and was subsequently adopted by low-functioning relatives at the age of 5.[1] Jordan was born with fetal alcohol syndrome and was later diagnosed with a variety of ailments, including cerebral palsy and impulse control problems. The Department came into contact with Jordan at age 7 and age 9, each time due to his running away from home and from school. In both cases, the caseworker felt that keeping Jordan in his family's home was in the family's best interest; therefore, the respective cases were closed upon prescribing the family more support services. In his third contact with the Department, at age 10, Jordan was removed from his home and eventually placed in a therapeutic foster home after two brief stays in other placements. Although Jordan's father was provided services to attempt reunification, it was determined that reunification would not be in Jordan's best interest because of the father's diminished mental capacity. Jordan's behavioral problems continued intermittently within his therapeutic foster home with some additional adverse behaviors; however, according to the caseworker, the therapeutic foster family was willing and able to continue working with Jordan while he was still placed in their care. At one point, Jordan stated he wanted the therapeutic foster home to be his adoptive family, but therapeutic foster homes cannot be a permanent placement for a child. After 3 years with the therapeutic foster home, at age 13, Jordan's foster family stated they were no longer able to care for him because of his escalating threatening behaviors toward the foster father, among other negative behaviors. He was subsequently placed in a congregate care facility in August 2011. His placement in congregate care began a consistent cycle of Jordan running away from a facility, being hospitalized or detained, and then subsequently being placed again in congregate care. Jordan has remained in various congregate care settings for about 3 years as of July 2014.

Case 2: Michael first came into contact with the Department at age 12 while under the care of his biological mother and her boyfriend.[1] Michael's brother (age 15) had been left by the boys' mother at their maternal aunt's house approximately 1 year earlier. When an altercation broke out between the brothers near their aunt's house, a neighbor made a call to the Department. Upon investigation, the Department determined that both boys had been neglected by their parents to the extent that emergency removal was necessary. The initial case goal was reunification for both boys, although their parents did not engage with the Department in this effort. Michael's brother was able to stay in family-based care for almost all of his time in out-of-home care, but Michael was not. One difference between the brothers was the relatively acute behavioral issues observed in Michael, who had been diagnosed with Asperger's syndrome. Initially, Michael was placed in a foster home; however, after an emergency behavioral health hospitalization, the Department moved him to a therapeutic group home. After 9 months at the group home, Michael was moved to a therapeutic foster home for 7 months, where he appeared to improve. Based on his improvement, it was decided that Michael was stable enough to live in a regular foster home setting. Michael was placed in two different foster homes within 4 months, both of which failed. According to Michael's caseworker, the first foster home and the school associated with this placement were unprepared to manage Michael's behavioral needs. Failure of the second foster home was reportedly due to Michael not receiving additional behavioral health services the foster parent had requested. Although Michael had a behavior coach, the foster parent did not feel that this was sufficient for a child with Asperger's syndrome. After these displacements, the Department placed Michael in a group home for children that have a developmental disability, where he has remained for about 16 months as of July 2014.

[1] Names have been changed.

Source: Auditor General staff review of case documentation and interviews with case managers.

FINDING 1

Department should continue taking actions to reduce the use of congregate care

The Arizona Department of Child Safety (Department) should continue taking actions to reduce the use of congregate care placements.[1] Not only has the number of Arizona children placed in out-of-home care increased, but the number of children placed in congregate care and the length of time they stay there have also increased. However, the use of congregate care placements may negatively affect the welfare of the children and result in additional costs to the State. Several factors have contributed to this increased use of congregate care, including an inadequate supply of licensed foster homes, various state practices, and inadequate access to behavioral health services. The Department should develop and implement a comprehensive approach to reduce the use of congregate care in Arizona that considers actions taken by other jurisdictions. In September 2014, the federal government approved a department plan to use federal funding to take such an approach.

Arizona's use of congregate care has increased

The number of Arizona children placed in congregate care increased between September 2009 and March 2014. This growth in Arizona's use of congregate care is contrary to nation-wide trends. Additionally, although congregate care has typically been used for older children, Arizona has increasingly placed younger children in this setting, and children placed in congregate care have spent increasing amounts of time there. The use of congregate care may have adverse effects on the children and is costly to the State.

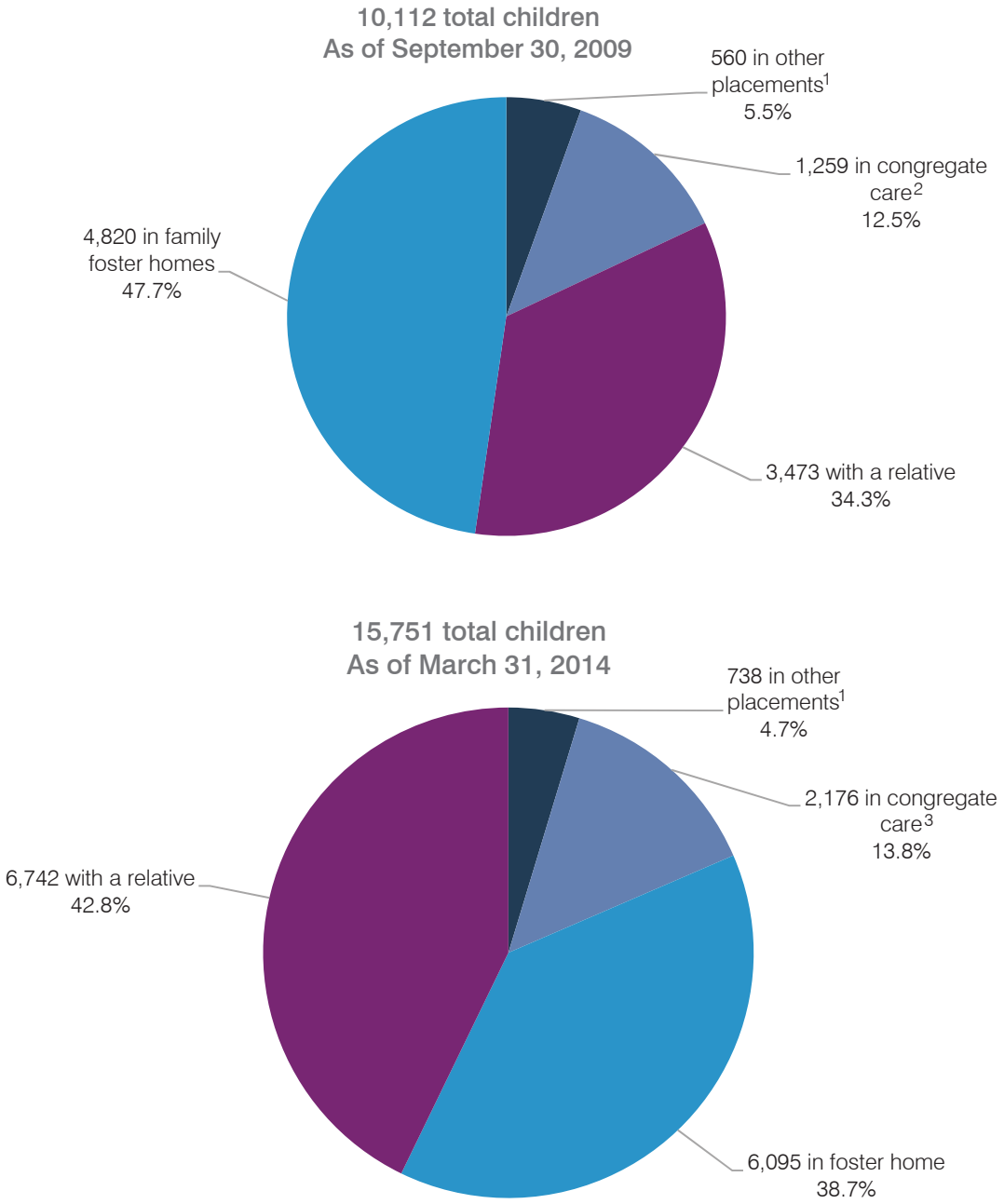
Number of children in congregate care has increased—As discussed in the Introduction (see pages 2 through 3), the number of Arizona children placed in out-of-home care grew approximately 56 percent between September 2009 and March 2014. Although this growth has occurred for all placement types, the growth in congregate care placements, particularly group homes, has been disproportionately large, increasing by approximately 73 percent over this time, from 1,259 to 2,176 children (see Figure 2, page 8).[2] As a result, the percentage of children in out-of-home care placed in congregate care increased from 12.5 percent of children in September 2009 to 14.6 percent in September 2013. However, this percentage decreased to 13.8 percent as of March 2014, although nearly 2,200 children remained in congregate care at this time. This overall increase runs counter to the Department's prior trend, in which the percentage of children in out-of-home care placed in congregate care fell from 22 percent in June 2005 to 12.5 percent in September 2009.

Arizona's growth in both of its out-of-home care and congregate care populations also runs counter to national trends. According to national data from the Adoption and Foster Care Analysis and Reporting System (AFCARS), most states have experienced a decline in both their out-of-

[1] This finding evaluates the use of congregate care placements between September 2009 and March 2014 by the former Division of Children, Youth and Families within the Arizona Department of Economic Security, which became the Arizona Department of Child Safety in May 2014. For readability, auditors use the term "Department" in reference to both the former division and the new department.

[2] The number of children in group homes increased approximately 88 percent, and the number of children in residential treatment (including shelters, detention, and hospital placements) increased approximately 47 percent.

Figure 2: Number of Arizona children in out-of-home care by placement type As of September 30, 2009 and March 31, 2014



[1] Other placements includes children in independent living, children who have run away or whose parents have absconded with them, and children preparing to return home through trial home visits.

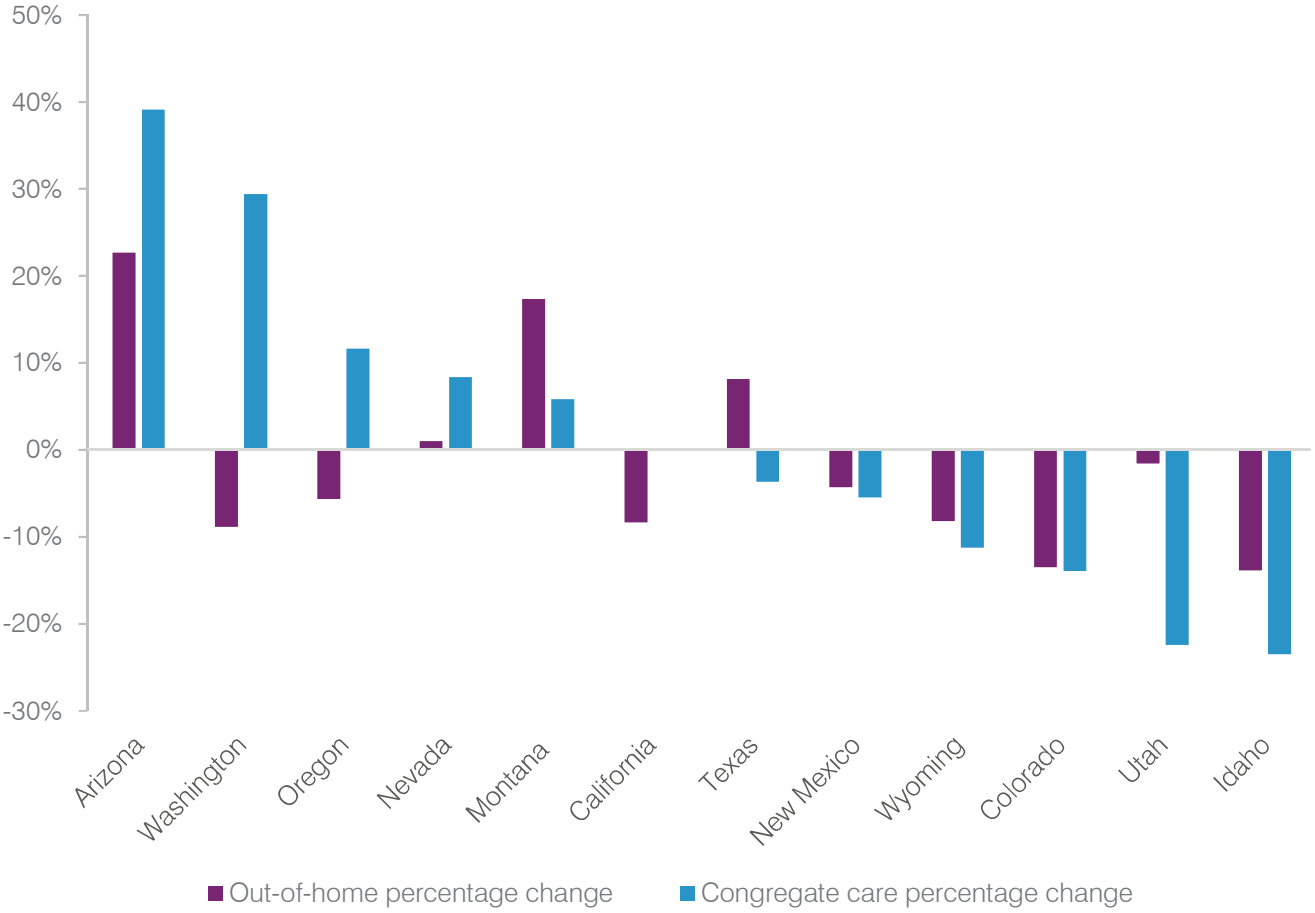
[2] Consists of 783 children in group homes and 476 children in residential treatment, including shelters, detention, and hospital placements.

[3] Consists of 1,475 children in group homes and 701 children in residential treatment, including shelters, detention, and hospital placements.

Source: Auditor General staff analysis of information from the Department's semi-annual child welfare reports for the periods ended September 30, 2009 and March 31, 2014.

home care and congregate care populations.[1] Although comparisons should be sensitive to potential differences in state child welfare systems, Figure 3 shows how Arizona's growth in these populations compares to that of other western states. Only two other western states, Montana and Nevada, reported growth in both populations. However, in contrast to Arizona and Nevada, Montana's congregate care population percentage growth was less than its out-of-home care population percentage growth. Further, according to the AFCARS data, the average percentage of children placed in congregate care for all 50 states decreased slightly, from 13.8 percent in

Figure 3: Percentage change in western states' out-of-home and congregate care populations[1] Federal fiscal years 2010 through 2012



[1] Auditors' analysis found that Missouri had a higher percentage growth in congregate care than Arizona, and Connecticut had a higher percentage growth in out-of-home care than Arizona; however, these states are not considered western states and, thus, were not included in the figure. Additionally, California had a negligible percentage change in its congregate care population.

Source: Auditor General staff analysis of AFCARS data for federal fiscal years 2010 through 2012.

[1] AFCARS is a federally mandated data collection system into which states must submit data on their respective foster care systems to the Children's Bureau of the U.S. Department of Health and Human Services' Administration on Children, Youth, and Families. The Children's Bureau provides AFCARS data annually to the National Data Archive on Child Abuse and Neglect (NDACAN) at Cornell University for distribution to interested parties. The AFCARS data used in this report was made available by NDACAN and has been used by permission. Neither the collector of the original data, the funder, NDACAN, Cornell University, or its agents or employees offer any assurance or accept any responsibility for the accuracy or comprehensiveness of the data provided or bear any responsibility for the analyses or interpretations presented here.

federal fiscal year 2010 to 13.4 percent in federal fiscal year 2012. In contrast, according to AFCARS data, the percentage of children in congregate care in Arizona grew from 12.5 percent to 14.2 percent during the same time period.

Use of congregate care has increased for younger children—In Arizona, younger children have been placed in congregate care at a higher rate than previously, according to an analysis of department data by Chapin Hall.[1] Chapin Hall analyzed department data on a number of factors including "predominant placement type," which is defined as the placement type where a child has spent more than 50 percent of his/her time during the first removal from home. Although the percentage of older Arizona children with a predominant placement type of congregate care has decreased, this has been offset by an increase in the percentage of children under 13 years of age with a predominant placement type of congregate care (see Table 2). Specifically, the percentage of Arizona children aged 12 years and younger with a predominant placement type of congregate care increased from 4.9 percent in calendar year 2009 to 8.4 percent in calendar year 2013.

Table 2: Percentage of Arizona children with congregate care as their predominant placement type As of December 31, 2009 through December 31, 2013

Calendar year	Children ages 12 and under	Children ages 13-17	Children, all ages
2009	4.9%	45.9%	14.4%
2010	3.9	45.2	12.7
2011	5.8	46.2	14.4
2012	6.8	42.6	13.9
2013	8.4	43.0	15.0

Source: Auditor General staff analysis of the Department's Children's Information Library and Data Source (CHILDS) data analyzed by Chapin Hall for the periods ended December 31, 2009 through December 31, 2013.

Length of time children spend in congregate care has increased—In addition to the increase in the number of Arizona children in congregate care, children placed in congregate care have stayed there longer. According to auditors' analysis of AFCARS data, the length of time Arizona's children stayed in their most recent congregate care placements increased by 41 percent, from 56 to 79 days between federal fiscal years 2010 and 2012 (see Table 3, page 11). In contrast, Arizona children's length of stay for other placement types has remained relatively stable or decreased over the same time period.

Use of congregate care may adversely affect children and is costly—According to child welfare experts, the best place for almost every child is with a family, either the child's biological family or with an individual or family that has made a long-term, legal commitment to the child.[2] Children in congregate care do not have the opportunity to form relationships with adults who can make such a commitment, which can delay or undermine permanency goals such as family reunification, adoption, or guardianship.[3] In addition, congregate care can also cause other unwanted effects. For example, children in congregate care may be

[1] Chapin Hall is a research and policy center at the University of Chicago focused on improving the well-being of children, youth, and families. Chapin Hall's research areas include child welfare and foster care systems.

[2] Annie E. Casey Foundation. (n.d.). *Case practice standards manual*. Baltimore, MD: Author; Feild, T. (2012). *Congregate care rightsizing: What's best for kids is also good for state budgets*. Baltimore, MD: Annie E. Casey Foundation, Child Welfare Strategy Group; and North American Council on Adoptable Children. (2005). *A family for every child: Strategies to achieve permanence for older foster children and youth. (Family to family: Tools for rebuilding foster care)*. Baltimore, MD: Annie E. Casey Foundation.

[3] Barth, R.P. (2002). *Institutions vs. foster homes: The empirical base for a century of action*. Chapel Hill, NC: School of Social Work, Jordan Institute for Families; and Freundlich, M., & Avery, R.J. (2005). Planning for permanency for youth in congregate care. *Children and Youth Services Review*, 27, 115-134.

Table 3: Median number of days Arizona children spent in their most recent placement setting[1] Federal fiscal years 2010 through 2012

	Placement type			
Federal fiscal year	With relative	Licensed foster home	Congregate care	Total out-of-home care
2010	226 days	213 days	56 days	188 days
2011	223	219	74	192
2012	199	222	79	187
Percentage change from 2010 to 2012	-12%	4%	41%	-1%

[1] The most recent placement setting refers to the placement setting that children were in as of September 30 in each year. For children who exited out-of-home care before September 30, the most recent placement setting refers to the placement setting the child was in immediately preceding his/her exit from out-of-home care.

Source: Auditor General staff analysis of AFCARS data for federal fiscal years 2010 through 2012.

more limited in their ability to visit with their biological families, creating a barrier to successful reunification.[1] When a child's permanency goal is family reunification, it is important that the child visits with his/her birth family to help maintain family connections.[2]

Studies have also found that when children "age out" of out-of-home care without achieving permanency, they experience worse outcomes than children who achieve permanency.[3,4] For example, children who age out have been found to have limited education and poor employment opportunities, and many are also homeless or incarcerated, and have mental or physical illnesses.[5] According to analysis by Chapin Hall, approximately 23 percent of Arizona children who entered out-of-home care in calendar year 2008 at ages 13 to 17 aged out of out-of-home care within 5 years.[6]

In addition to delaying or hindering permanency, congregate care may pose threats to children's safety and well-being in the short- and long-term. Specifically:

- Children in congregate care may be at a higher risk for placement instability.[7] Children who are placed in congregate care have likely already had at least one placement fail, whether it was a relative or foster home placement. Placement instability may put children at a higher

[1] Barth, 2002; Freundlich & Avery, 2005

[2] Freundlich & Avery, 2005

[3] Freundlich & Avery, 2005

[4] Aging out refers to a child's exit from the system because of his/her age. According to department policy, children are able to exit care when they turn 18; however, children may sign a voluntary foster care agreement and stay in care until they are 21.

[5] North American Council on Adoptable Children, 2005

[6] The 5 years reflects the time that it would take for a 13-year-old child to potentially age out of the system at age 18.

[7] Lee, B.R., Bright, C.L., Svoboda, D., Fakunmoju, S., & Barth, R.P. (2011). *Outcomes of group care for youth: A review of comparative studies. Research on Social Work Practice*, 21(2), 177-189; and Ryan, J.P., Marshall, J.M., Herz, D., & Hernandez, P.M. (2008). Juvenile delinquency in child welfare: Investigating group home effects. *Children and Youth Services Review*, 30, 1088-1099.

risk for juvenile delinquency, and may create feelings of insecurity and dissatisfaction with the foster care experience overall.[1]

- Several studies have reported that adolescents placed in congregate care are more likely than their peers in foster homes to be arrested post-discharge.[2]

- According to one study, older children in congregate care are more likely to continue problematic, sexualized behaviors, whereas children in foster homes are more likely to cease such behaviors.[3]

- In a series of studies reporting on interviews of foster children years after their exit from out-of-home care, researchers found that children who were cared for in foster homes, rather than congregate care, were more likely to have attained higher levels of education and reported fewer substance abuse problems.[4] They were more satisfied with their income levels, had more positive assessments of their lives, and were more likely to have close friends and stronger informal support.

- The highly structured environment in most congregate care settings can exacerbate the educational deficiencies children typically have when they enter out-of-home care.[5] The structured setting limits children in carrying out activities such as shopping for groceries or preparing food, which help prepare individuals to care for themselves.

Congregate care is also much more expensive than family-based placements, and the increased number of children and length of stays in congregate care has contributed to a considerable increase in expenditures for congregate care services. As shown in Table 4 (see page 13), the Department's expenditures for congregate care services nearly doubled between fiscal years 2009 and 2013, from nearly $40 million to more than $79 million.

Several factors have led to increased use of congregate care

Literature on the use of congregate care and experts in the field indicate that many factors can contribute to an increase in or inappropriate use of congregate care by child welfare agencies. Based on a review of literature, other jurisdictions' efforts to reduce congregate care use, two separate case studies of children in congregate care spanning several years, and interviews with more than 30 individuals, including department staff and management, congregate care providers, child-placing agencies, and child welfare experts, auditors identified several factors that are relevant to the use of congregate care in Arizona. These include an inadequate supply of licensed foster homes, various department practices, and inadequate access to behavioral health services for children in foster homes. Specifically:

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1 Ryan et al., 2008

2 Barth, 2002; Lee et al., 2008; Ryan et al., 2008

3 Lee et al., 2008

4 Barth, 2002

5 Barth, 2002

Table 4: Schedule of Arizona congregate care expenditures for fiscal years 2009 through 2013 and number of Arizona children in congregate care as of March 31 for each of these fiscal years (Unaudited)

	2009	2010	2011	2012	2013
Congregate care placement type					
Group homes[1]	$ 29,729,361	$ 28,385,710	$ 32,416,380	$ 43,959,891	$ 58,825,483
Emergency shelters	7,832,344	6,747,489	8,369,702	13,081,858	14,783,966
Residential treatment centers	2,032,294	1,789,090	2,882,147	4,841,335	5,552,557
Total congregate care expenditures	$ 39,593,999	$ 36,922,289	$ 43,668,229	$ 61,883,084	$ 79,162,006
Number of children in congregate care as of March 31	1,375	1,228	1,387	1,771	2,112

[1] Includes therapeutic group homes and behavioral health group homes.

Source: Auditor General staff analysis of CHILDS *Report 87* for fiscal years 2009 through 2013 and information from the Department's semi-annual child welfare reports for the periods ended March 31, 2009 through March 31, 2014.

- **Inadequate supply of licensed foster homes**—According to child welfare experts, an inadequate supply of quality foster homes affects child welfare agencies' ability to serve children in family-based settings and leads to overuse of congregate care.[1] The Department reported that it does not have enough foster homes to accommodate the growth in out-of-home care. Although the number of Arizona children in out-of-home care increased approximately 56 percent from September 2009 to March 2014, there was not a corresponding increase in the number of licensed foster homes. In fact, according to department reports, the number of licensed foster homes actually decreased from 3,954 homes in September 2009 to 3,480 homes in March 2012 before increasing to 4,329 homes in March 2014.[2] New foster homes were licensed throughout this time period, but existing foster homes also closed their licenses.[3] As a result, although the number of children placed in foster homes increased by 1,275 from September 2009 to March 2014, the percentage of children placed in licensed foster homes decreased from approximately 48 percent to 39 percent (see Figure 2, page 8). The Department has offset much of this decrease through an increased use of placements with relatives, but the inadequate supply of licensed foster homes has contributed to the Department's increased use of congregate care.

  Additionally, the Department has not successfully recruited the various types of licensed foster homes it needs. For example, according to department staff, foster families in the State are generally reluctant to care for older children. As of September 2013, about one-quarter of the

[1] Annie E. Casey Foundation. (2013). *When child welfare works: A working paper* [A proposal to finance best practices]. Baltimore, MD: Author; and Murphy, A.L., Van Zyl, R., Collins-Camargo, C., & Sullivan, D. (2012). Assessing systemic barriers to permanency achievement for children in out-of-home care: Development of the child permanency barriers scale. *Child Welfare*, 91(5), 37-7.

[2] The 4,329 foster homes represent a capacity of 9,049 spaces. Of these spaces, 2,413 were unavailable for placements, and 1,169 were available but unused because a match between these spaces and children's needs was not possible. According to department staff, spaces may be unavailable for placement for various reasons such as the foster home requesting a hold on placements because of personal circumstances or the Department putting placements at a particular home on hold because of a licensing issue or an investigation of the home.

[3] According to department reports, approximately 700 foster home licenses were closed on average every 6 months from October 2010 to March 2014. The top three reported reasons for license closure during this period were (1) adoption or guardianship, (2) license expired/closed by the Department, and (3) other time commitments/priorities.

children in the State's out-of-home care population were age 13 or older. Although most of these older children were placed with relatives or in foster homes, one-third were placed in congregate care settings, representing approximately 70 percent of all placements in congregate care. Department staff also indicated that there are not enough licensed foster homes that can care for children with special needs or that are able to take sibling groups. As a result, children with these characteristics are more frequently placed in congregate care. Further, department staff and child-placing agencies indicated that foster parents may have unrealistic expectations about fostering and may not be prepared or adequately trained to manage the behaviors of the children placed in their care, which can lead to placement disruptions and children being placed in congregate care.

Inadequate department oversight of foster home recruitment and retention has likely contributed to these issues. The Arizona Department of Economic Security, which formerly housed the Department, contracted with licensed child-placing agencies to provide most services related to foster home recruitment, including recruiting and training foster parents, assisting foster parents through the licensure process, and supervising and monitoring licensed foster parents. Although the Department maintained primary responsibility for the general recruitment of foster homes, the contracts required child-placing agencies to develop and implement targeted recruitment plans that included strategies for finding homes for specific populations identified by the Department, such as sibling groups, older children, and specific ethnic groups, and for finding homes within specific geographic areas for which there are recruitment needs. However, as reported in the Office of the Auditor General's report on contracts for foster home recruitment-related services (see Report No. CPS-1301), the Arizona Department of Economic Security had not adequately implemented its performance-based contracts for these services. Specifically, its contracts lacked adequate performance measures, appropriate ties between contractor performance and department monitoring, and workable financial incentives. The Arizona Department of Economic Security planned to revise and rebid the contracts, and auditors recommended that it engage in a collaborative planning process with appropriate stakeholders to address these contracting deficiencies. The Department reported that it will contract for these services directly rather than contract through the Arizona Department of Economic Security, and is working to implement the recommendations from this report.

Finally, the Department indicated that it could do a better job of supporting foster families, and that this could help improve retention rates. This assertion is supported by two surveys of Arizona foster families, which suggest that some foster parents may not be receiving adequate support.[1] In both surveys, foster parents identified several factors that affect their desire or ability to provide foster care or that could be improved. Factors identified in either or both surveys included:

- Difficulty in accessing and maintaining behavioral health and respite services;
- Poor communication from the Department and child-placing agencies about children's cases;

[1] Arizona State University, College of Public Programs, School of Social Work. (2014). *Voluntary closure study: Former foster care families in Arizona*. Tempe, AZ: Author; and Geiger, J.M., Hayes, M.J., & Lietz, C.A. (2013). Should I stay or should I go? A mixed methods study examining the factors influencing foster parents' decisions to continue or discontinue providing foster care. *Children and Youth Services Review*, 35, 1356-1365.

- Lack of input in decision-making processes that affect the children in their care;
- Lack of respect and sensitivity in department interactions;
- Additional funds to support the needs of children; and
- More appreciation and respect from department staff.

Permanency planning—A process through which planned and systematic efforts are made to ensure that children and youth are in safe and nurturing relationships expected to last a lifetime. Permanency planning involves time-limited, goal-oriented activities to maintain children within their families of origin, including kin, or to place them with other permanent families through adoption or guardianship.

Source: Child Welfare Information Gateway Glossary.

- **Various department practices—**Several department practices may have also contributed to the increased use of congregate care in Arizona. Some of these practices relate to permanency planning (see textbox) such as the use of independent living and long-term foster care as permanency goals, insufficient permanency planning activities, and a bias against permanency for older children. Other practices include allowing children to stay in congregate care based on their preferences, inadequate and inaccurate provision of information about children needing foster home placements, insufficient transitional activities for children changing placements, poorly matched foster home placements, and other systemic department problems. Specifically:
  - **Use of independent living and long-term foster care as permanency goals—**The Department uses both independent living and long-term foster care as permanency (i.e., case plan) goals (see textbox). According to department policy, these goals are the least preferred permanency goals. The Department uses independent living as a permanency goal for older children only, and uses it more often for children in congregate care (see Table 5, page 16). Long-term foster care is used to a lesser extent than independent living, and generally for older children in licensed foster homes and congregate care.

    However, child welfare experts have expressed concerns about the use of these goals because they do not steer children toward permanent families.[1] As discussed previously (see pages 11 through 12), when children age out of foster care without permanent connections, they can experience poor outcomes. Because independent living is not a family-based permanency goal, its use may disincentivize department staff to look for permanent families for children with this

Independent living—A program that provides older children and eligible youth in out-of-home care with independent living services to help prepare them for self-sufficiency in adulthood. They can receive these services while they are living in any type of out-of-home care placement (such as kinship care, family foster care, or residential/group care). Youth receiving independent living services can be working toward achieving any of the permanency goals (such as reunification, adoption, or guardianship), or they may be heading toward emancipation from (aging out of) foster care to adulthood on their own. Independent living services generally include assistance with money management skills, educational assistance, household management skills, employment preparation, and other services.

Long-term foster care—The placement of a child in foster care for an extended period of time.

Source: Child Welfare Information Gateway Glossary

[1] Freundlich & Avery, 2005; North American Council on Adoptable Children, 2005

Table 5: Number and percentage of Arizona children ages 13 and older in each placement type with an independent living or a long-term foster care permanency goal as of September 30, 2013

	Placement type		
Permanency goal	**Congregate care**	**Licensed foster home**	**With a relative**
Independent living			
Number of children	474	200	96
Percent	34.7%	19.3%	13.1%
Long-term foster care			
Number of children	114	126	13
Percent	8.3%	12.2%	1.8%
Total			
Number of children	588	326	109
Percent	43.0%	31.5%	14.9%

Source: Auditor General staff analysis of CHILDS data provided by department staff as of September 30, 2013.

goal, which may mean longer stays for the children in congregate care settings. The North American Council on Adoptable Children indicates that the use of independent living as a permanency goal by child welfare agencies is often not accompanied by a search for permanent families. It also reports that although independent living programs provide some benefits, such as education and employment stipends, these programs are not a substitute for permanency planning. Further, according to the U.S. Department of Health and Human Services, Administration for Children & Families, Child Welfare Information Gateway, the federal Adoption and Safe Families Act does not recognize long-term foster care as a permanency option and, increasingly, state child welfare systems no longer view long-term foster care as a placement alternative. Finally, national data suggests that both goals are overused for older children.[1] As shown in Table 5, as of September 2013, approximately 43 percent of Arizona children ages 13 and older in congregate care settings, 32 percent of children ages 13 and older in licensed foster homes, and 15 percent of children ages 13 and older living with relatives had a permanency goal of independent living or long-term foster care.

- **Insufficient permanency planning activities**—Reviews of reform in congregate care by other jurisdictions, as well as an expert auditors interviewed, cited a lack of permanency planning as a contributing factor to congregate care use by child welfare agencies nationally. Enhanced permanency planning is one way child welfare agencies can improve permanency outcomes, especially for older children in congregate care.[2] Department staff indicated that increased permanency planning activities could help reduce the number of Arizona children in congregate care. Two department regions reported success in using permanency roundtables, which are structured meetings involving internal and external experts intended to achieve permanency for specific

[1] North American Council on Adoptable Children, 2005

[2] Freundlich & Avery, 2005; North American Council on Adoptable Children, 2005

youth. For example, according to the Department, in one region, approximately 20 percent of the cases staff reviewed in the roundtables had youth exit foster care to a permanent family-based setting. However, according to department staff, these roundtables were placed on hold when department staff began reviewing the uninvestigated cases reported in November 2013. Additionally, department staff indicated that efforts such as the roundtables have been too limited in scope, and would like to see such efforts applied more comprehensively department-wide.

- **Bias against permanency for older children—**Child welfare experts have observed a bias against permanency for older children in child welfare agencies, which undermines effective permanency planning for these children.[1] Examples of this bias include assumptions that older children are not adoptable and have unmanageable behavioral issues, assumptions that research has not supported.[2] According to the North American Council on Adoptable Children, the primary issue in youth permanency planning is believing permanency is possible. In a 2005 study of New York City's child welfare system, researchers found that negative beliefs held by agency staff about youth in congregate care may have contributed to caseworker reluctance to work toward permanent case plan goals.[3] Auditors observed a similar bias in discussions with agency staff, which may be affecting permanency planning efforts for older children. For example, department staff indicated that older children require a higher level of care that families cannot provide, that older children come into foster care with life experiences that some foster parents do not want incorporated into their homes, and that the behavior of older children often scares some foster parents, which can make it difficult to place them in some foster homes. In addition, auditors noted this bias in one case study reviewed (see Case 2 in the textbox on page 5). Specifically, after the child was placed in a group home, his case plan goal of adoption or guardianship was changed to independent living. The department supervisor overseeing this case attributed this change to the child's age (15) and to the fact that there were no candidates for adoption or guardianship at the time.

- **Allowing some children who wish to stay in congregate care to do so—**According to department staff, some older children prefer living in congregate care settings versus foster homes. Staff cited many possible reasons for this preference, including past foster home disruptions, a fear of becoming emotionally attached, a preference for the clear behavioral expectations that exist in congregate care settings versus the ambiguity that can exist in family foster homes, and a desire to maintain a sense of loyalty to their biological families. According to staff, this age group may purposefully disrupt from foster homes in order to be placed in or return to a congregate care setting. Literature indicates it is a common perception in child welfare agencies that older children in congregate care do not wish to be in family-based placements, but that these perceptions are often misguided and based on negative stereotypes of older children and a lack of permanency planning by congregate care professionals.[4] Group homes are typically not focused on permanency planning, which serves to undermine adoption or reunification. In addition, caseworkers do not believe it is the role of congregate care providers to engage in permanency planning, which

[1] North American Council on Adoptable Children, 2005

[2] Barth, 2002; Freundlich & Avery, 2005; North American Council on Adoptable Children, 2005

[3] Freundlich & Avery, 2005

[4] Freundlich & Avery, 2005

may leave children there longer than necessary. In one 2005 study of youth in congregate care in New York City, professionals and foster youth reported that family-based permanency was not consistently addressed with youth while they were in congregate care.[1] Foster children themselves reported that the system either prevented them from reuniting with their families or did little to support or facilitate efforts to maintain these connections. Moreover, some of the children interviewed in the study felt they were not sufficiently included in their own planning, and many did not think congregate care met their needs.

- **Inadequate or inaccurate information provided about children—**According to a January 2014 survey of foster and adoptive parents, 58 percent of respondents felt they had inadequate information about the children placed in their homes.[2] Child-placing agencies also stated that they sometimes receive inadequate or inaccurate information from department staff about children in need of foster home placements. Inadequate or inaccurate information can lead to unnecessary placement disruptions because foster parents may not be prepared for or licensed to care for the children, which can then lead to congregate care placements. Further, one department placement supervisor indicated that foster home placements could be increased to some extent if the Department was able to provide more timely and accurate information about children to child-placing agencies and even potential foster parents.

- **Insufficient transitional activities—**Department policy requires staff to develop transition plans when children change placements. These plans should address several areas, including communication between the current and new caregivers, pre-placement contact and visitation between the child and new caregivers, and the supports and services the child, current caregivers, and/or new caregivers should receive during the transition period. Two congregate care providers auditors interviewed (which are also child-placing agencies) stated that when such planning occurs, foster home placements have a higher probability of success. However, these providers indicated that transitional activities are sometimes lacking, such as in emergency foster home placements, which can lead to placement disruptions and subsequent congregate care placement, as well as disruptions to a child's services.

- **Poorly matched children and foster homes—**Department staff may make foster home placement decisions that do not adequately address children's needs. Literature suggests this may to be due to the pressures to find a placement, and identifies the failure to match children's needs with the capabilities of foster families as a barrier to permanency and a cause of placement disruption, which can increase the likelihood of congregate care placement.[3] Auditors observed the effects of a poorly matched foster home placement in one of the cases discussed previously (see Case 2 in the textbox on page 5). The child, who was diagnosed with Asperger's syndrome, was

[1] Freundlich & Avery, 2005

[2] This survey was conducted by the Child Advocate Response Examination (CARE) Team in cooperation with the Arizona Association for Foster and Adoptive Parents. The CARE Team was created by the Governor in response to the revelation in November 2013 that department staff intentionally did not investigate nearly 6,600 child abuse and neglect reports. The CARE Team was tasked with overseeing the investigations of these cases; assessing department policies, procedures, and personnel; and making recommendations for change.

[3] Murphy et al, 2012 and Sudol, T. (2009). *Placement stability information packet*. New York, NY: National Resource Center for Permanency and Family Connections, Silberman School of Social Work at Hunter College, City of New York University.

placed with foster parents who were ill-equipped to manage his needs and in a school that could not facilitate his learning needs. As a result, the foster home placement failed after 1 month. The case manager indicated to auditors that he was under pressure to move the child quickly because the therapeutic foster home the child had been residing in prior to the foster home was costly.

- **Systemic department problems—**According to the Department, several systemic problems may have also contributed to an inappropriate use of congregate care. In January 2014, the Governor's CARE Team reported that the volume of incoming cases exceeded the Department's capacity, which had led to high staff caseloads, caseload backlogs, high staff turnover, ineffective management practices, insufficient staff training, and a culture that allowed individual judgment to substitute for standardized processes. In discussions with auditors, department management and staff indicated that at least some of these problems have exacerbated its use of congregate care. In addition, department staff indicated that if caseworkers had smaller caseloads, they would be able to more successfully aid children in achieving permanent outcomes. The Legislature appropriated funding to the Department in fiscal years 2014 and 2015 to hire additional caseworkers and other staff to help reduce the Department's staff caseloads. The Department is required to submit monthly reports to the Governor and Legislature on its progress in hiring staff. In its July 2014 report, the Department reported that it continued to make progress in filling its new staff positions but still had vacancies. For example, the Department reported having filled 1,309 of 1,406 caseworker positions (97 vacancies) compared to having filled 1,190 of 1,320 positions (130 vacancies) as of February 2014.

- **Inadequate access to behavioral health services—**Children, especially older children, who are removed from their homes often require behavioral health services to address symptoms of neglect and abuse.[1] For example, according to department data, as of September 2013, approximately 31 percent of the children in out-of-home care aged 13 or older were clinically diagnosed as emotionally disturbed. Although some children with behavioral health needs will require treatment in a congregate care setting, child welfare experts believe that even children with specialized needs can be cared for in a family setting with the right supports.[2] However, according to literature, child welfare agencies are often not able to adequately provide therapeutic services in family-based settings.[3] One expert auditors interviewed explained that when child welfare agencies do not have a strong therapeutic foster home system that could provide therapeutic services in family-based settings, children with high levels of need may end up going to congregate care.

  In Arizona, therapeutic foster homes are licensed by the Arizona Department of Health Services and represent one option to meet children's behavioral health needs outside of a congregate care setting. However, department staff indicated that therapeutic foster homes are designed for temporary stays; therefore, they are not long-term solutions for children in need of continued support. Children whose behavioral health improves in therapeutic foster homes may be moved to less-restrictive family settings, but without the same continued support, their behaviors may

[1] North American Council on Adoptable Children, 2005

[2] Albert & Meezan, 2012; and Feild, T. (2012). *Congregate care rightsizing: What's best for kids is also good for state budgets*. Baltimore, MD: Annie E. Casey Foundation, Child Welfare Strategy Group.

[3] Feild, 2012

worsen, resulting in placement disruptions and subsequent placement in congregate care. This occurred in one case auditors reviewed (see Case 2 in the textbox on page 5). As explained in the textbox, the child was moved out of a therapeutic foster home after his behaviors improved and subsequently placed in two foster homes, both of which failed. The first foster home placement failed because the home and associated school were not equipped to manage his needs; the second placement failed because the child did not receive additional behavioral health services the foster parent had requested for him. Specifically, she requested that the child receive therapy from a professional qualified to treat a child with Asperger's syndrome. Because the child did not receive this service, she discontinued fostering him, which resulted in him being placed in congregate care. The case manager for this case explained that foster parents are often frustrated because of the difficulty they face in obtaining needed behavioral health services. This concern was also reported in the January 2014 survey of foster and adoptive parents conducted by the CARE Team (see page 18, footnote 1, for additional information), as well as the two surveys of Arizona foster families discussed on pages 14 through 15.

Similar to other jurisdictions, Arizona should take comprehensive approach to reduce congregate care use

Various other jurisdictions have taken actions to minimize the use of congregate care that can provide a model approach for Arizona. To assess what steps the Department might take to reduce dependence on congregate care, auditors reviewed literature on the various actions and initiatives taken by several other jurisdictions. The steps auditors identified take a variety of forms, such as changing the array of services provided or policies and staff practices. The Department has taken some actions to reduce congregate care use in Arizona, but other jurisdictions' experiences in making improvements suggest that a more comprehensive and coordinated approach is needed. The Department should similarly develop and implement a coordinated approach that employs multiple strategies to reduce the use of congregate care in Arizona. In September 2014, the federal government approved a department plan to use federal funding to take such an approach.

Other jurisdictions have taken various actions to minimize their use of congregate care—Several jurisdictions identified in auditors' review of literature—including Connecticut, Maine, Tennessee, Virginia, and New York City—have partnered with outside organizations to develop and implement specific strategies for improving child welfare systems, including reducing the use of congregate care. According to auditors' review, these jurisdictions implemented a variety of solutions across five areas to minimize the use of congregate care. The five areas were (1) service array; (2) frontline practice; (3) finance; (4) performance management; and (5) policy and regulation (see Table 6, page 21, for definitions and examples of actions taken).[1] Along with reducing the use of congregate care, a case study reporting on the strategies for three of these jurisdictions documented improved performance in other key aspects of out-of-home care, including shortened stays, better rates of

[1] The Annie E. Casey Foundation's Child Welfare Strategy Group developed the five area framework for the Annie E. Casey Foundation's rightsizing congregate care initiatives. See Noonan, K., & Menashi, D. (2010). *Rightsizing congregate care: A powerful first step in transforming child welfare systems.* Baltimore, MD: Annie E. Casey Foundation.

Table 6: Example actions taken by jurisdictions to reduce the use of congregate care

Area[1]	Example actions
(1) **Service array**: The array of public and private programs, placements, and service options available for children and families.	• Close public congregate care facilities • Implement a continuum model of care to help ensure that providers provide services and placements beyond just congregate care • Use targeted recruitment to increase the pool of quality foster homes • Enhance foster parent training and support • Provide community-based services to children and families • Focus on increasing the use of relatives and other family settings to reduce congregate care
(2) **Frontline practice**: The way child welfare agency staff interact on a day-to-day basis with clients.	• Engage children, families, and other stakeholders in decision-making • Improve training programs for child welfare staff • Implement a validated assessment tool to help ensure appropriate placements
(3) **Finance**: The model for funding services.	• Use financial disincentives for congregate care • Shift funding from congregate care to community-based services • Explore different cost models to improve service delivery, such as allowing clinicians who serve children in group settings to provide transitional services in a family setting
(4) **Performance management**: The use of outcome measures and trends to make decisions and guide the agency.	• Use performance measures in contracts to evaluate providers and eliminate poorly performing providers • Evaluate staff using performance data to promote a decreased use of congregate care
(5) **Policy and regulation**: The official rules and regulations that underpin the day-to-day practice of child welfare workers.	• Institute gatekeeping strategies for congregate care, including prior authorization and utilization reviews • Prohibit congregate care placement for certain age groups

[1] The Annie E. Casey Foundation's Child Welfare Strategy Group developed the five area framework. For definitions of the five areas, see *Helping Government Agencies Become More Effective and Efficient: Discovering 'Catalytic Combinations' in Public Child Welfare Reform*.

Source: Auditor General staff summary of literature on other jurisdictions' congregate care reform efforts (see Appendix A, pages a-1 through a-6, for more detailed information and specific citations).

permanent placements, and improved percentages of children aging out who leave the child welfare system with strong community and family connections.[1]

Because each state has unique strengths and challenges to reducing the use of congregate care, the strategies that a particular state implements should be tailored to its specific circumstances. Literature indicates that jurisdictions can more effectively improve their overall child welfare systems by taking action in multiple areas, rather than implementing solutions within a single area.[2] This multi-pronged strategy stems from the broader governing idea of addressing problems through a combination of actions. Still, it is not necessary to implement solutions across the five areas all at once in order to realize systematic change and reduce the use of congregate care.

[1] Menashi, D., Behan, C., & Noonan, K. (2012). Helping government agencies become more effective and efficient: Discovering 'catalytic combinations' in public child welfare reform. *The Foundation Review*, 4(1), Art. 3.

[2] Menashi, Behan, & Noonan, 2012

The textbox below provides examples of the combination of actions taken by two of these five jurisdictions—Tennessee and Maine. Appendix A, pages a-1 through a-6, provides more detailed information about the actions taken to reduce the use of congregate care by all five jurisdictions.

Examples of state strategies for reducing congregate care use

Tennessee—The impetus for reducing the use of congregate care in Tennessee was a class action lawsuit that was settled in 2001. The lawsuit alleged that the Department routinely placed children in congregate care settings when it was not in their best interests. The state implemented a variety of actions to reduce the use of congregate care. Specifically, it closed a large public congregate care facility that had been serving children in state custody and worked with those youth to identify family-based placements. Through these efforts, many of the youth previously placed in the facility were placed with other family and friends or returned to their parents. In addition, the state enhanced its foster home development and recruitment by targeting homes that were equipped to care for teenagers and children who displayed emotional or behavioral problems.

Tennessee also took dramatic steps in implementing a continuum of services contracting model for procuring services. This model requires providers with congregate care contracts to maintain an array of services, such as residential treatment facilities, group homes, treatment foster care, and in-home services, rather than just providing residential care, in order to best meet the children's needs. Under this model, providers are paid the same rate no matter where they place a child, and because congregate care is more expensive than providing services in a foster home, providers have an incentive to place children in family-based settings. As a result of these changes, the percentage of Tennessee children in out-of-home care placed in congregate care decreased from 22 percent in January 2001 to 9 percent in January 2009. The continuum model successfully allowed providers to serve children with complex needs in family settings while controlling the high cost of congregate care. As of 2009, Tennessee had exceeded its goals, serving 95 percent of all moderately disturbed children and 75 percent of severely disturbed children in family settings.

Maine—In 2004, more than 27 percent of the children in Maine's foster-care system were placed in congregate care, exceeding the national average by 10 percent at the time. The state also had a bias against placement with relatives, and, as a result, children were placed far from their homes and communities and could be placed out of state. Maine took several steps to address the use of congregate care and improve the placement of children in family-like settings. For example, Maine's initial changes focused on new policies that made it difficult to place and keep children in congregate care, such as requiring prior authorization and utilization reviews for institutional placements. Maine also created teams designed to work with children and families to brainstorm ways to move children out of institutional settings. These and other steps to reduce the use of congregate care led to other system-wide changes, such as shifting $4 million in funding from congregate care placements to family- and community-based services. By July 2011, Maine managed to reduce the percentage of children placed in institutional settings to 5 percent.

Source: Auditor General staff summary of reform efforts in Tennessee and Maine reported in literature: See Moving Away from Congregate Care: One State's Path to Reform and Lessons from the Field (2012); What Works in Child Welfare Reform: Reducing Reliance on Congregate Care in Tennessee (2011); and Helping Government Agencies Become More Effective and Efficient: Discovering 'Catalytic Combinations' in Public Child Welfare Reform (2012).

Some states have also made legislative changes that help to reduce the use of congregate care, either independent of or in conjunction with the various strategies implemented by child welfare agencies discussed above. For example, Maine repealed laws allowing long-term foster care as a permanency goal because it created a disincentive for caseworkers to find a

permanent family for these children.[1] In addition, California passed a law highlighting the need to engage children in making placement decisions. Specifically, that law requires social workers to seek input from youth over the age of 10 and in group homes to identify and take action to support those relationships that are important to the youth. Further, laws in California and Washington allow for reinstatement of parental rights under certain conditions, which allows for potential reunification. For example, California allows a child who has not been adopted after at least 3 years from the termination of parental rights to petition the juvenile court for reinstatement of those rights.

Department has taken some actions to minimize congregate care use, but additional actions needed—The Department has implemented some actions that can help to minimize the use of congregate care and indicated it plans to continue working on additional actions to reduce its use. For example, the Department has worked to improve the recruitment and retention of foster parents through various avenues. Specifically, it has partnered with faith-based groups such as Arizona 1.27, a church-based group that trains local churches on recruiting and supporting church members engaged in foster care and adoption. The Department also has tried to improve its understanding of foster parent retention issues by commissioning a survey on foster home closure and foster parent retention, one of the two surveys discussed on pages 14 through 15. Further, based on recommendations provided in a previous Office of the Auditor General report (see Report No. CPS-1301), it is developing an improved performance-based contract for its foster home recruitment-related services. The Department has also made efforts to reduce the use of congregate care by seeking input from children and families in making placement decisions. Specifically, department policy requires team decision making for removal and placement decisions.[2] Additionally, department staff reported achieving promising results in regions that have used the permanency roundtables discussed on pages 16 through 17.

The Department has also indicated it plans to implement steps to reduce the overall number of children entering out-of-home care. Specifically, the Department plans to implement a differential response system and bolster services aimed at strengthening families and preventing the need for removal. Differential response is a practice that allows for more than one method of initial response to reports of child abuse and neglect. Typically, differential response allows for (1) an investigation of a report of abuse and neglect or (2) an alternative response, which involves assessing the family's strengths and needs and offering services. Alternative responses typically do not require substantiation of the alleged abuse/neglect and allow for children to remain in the home. The Department also reported that it has begun discussions with Arizona State University to develop a validated risk and needs assessment tool that would be used throughout a child's involvement with the child welfare system. Because mechanisms that would reduce the overall out-of-home care population would also likely reduce the use of congregate care over time, the Department should continue to assess what actions it can take to appropriately reduce the number of children entering out-of-home care.

Further, in August 2014, the Department submitted a Title IV-E waiver demonstration project application to the U.S. Department of Health and Human Services, wherein it outlines a plan to

[1] Freundlich, M. (2010). *Legislative strategies to safely reduce the number of children in foster care*. Denver, CO: National Conference of State Legislatures.

[2] A team decision-making meeting represents a strength-based decision-making process to address the safety and placement of children. This is a collaborative process involving the Department, family (custodial and noncustodial parents and the child age 12 and older), family support, community members, and partnering agencies including, as applicable, tribal representatives.

redesign its current congregate care system.[1] In the application, the Department indicated that all aspects of congregate care will be analyzed to examine why congregate care use has increased, its impact on children, and the most promising opportunities for reducing its use. As part of its efforts to develop solutions for congregate care, the Department will research the best practices used in jurisdictions with demonstrated congregate care reductions and review previous department efforts to reduce the use of congregate care. The Department also plans to engage various stakeholders as part of its work, including partnering with Arizona State University on several areas within the project. For example, the Department plans to work with Arizona State University to design an evaluation approach to determine the impact and effectiveness of its selected solutions. The Department reported that this application was approved on September 30, 2014.

In conjunction with the proposals outlined in its Title IV-E waiver demonstration project application, the Department should develop and implement a coordinated approach using multiple strategies to reduce the use of congregate care in Arizona. In developing this approach, the Department should consider various strategies, such as those used in other jurisdictions, that address the causes for increased congregate care use identified in this report and/or through its own analyses, such as:

- Continuing to look for ways to improve the recruitment and retention of foster families;

- Developing improved practices to establish permanency, including minimizing the use of independent living and long-term foster care as permanency goals and increasing permanency planning activities such as permanency roundtables;

- Instituting policy changes that would restrict the use of congregate care, such as requiring preauthorization for placing a child in congregate care or prohibiting its use for young children;

- Developing performance-based contracts to identify and eliminate poorly performing congregate care service providers; and

- Working with providers to improve the provision, array, and coordination of evidence-based services, including behavioral health services.

In addition, the Department should establish a plan and time frame for reinstituting the use of foster care receiving homes, which are temporary family-based foster home settings available for immediate use when children are taken into custody. The Department reported that it stopped using receiving homes in 2006 when it implemented its contracts for foster home recruitment-related services. The Department indicated that one goal of implementing these contracts was to ensure that all licensed foster parents could receive children at all times, but this ultimately proved to be difficult when trying to place a child at night or on weekends. Beginning in fiscal year 2014, the Legislature has appropriated funding to the Department to provide for 200 placements in foster care receiving homes, but the Department reported that

[1] Title IV-E waivers grant states more flexibility in using federal funds to test innovative approaches to child welfare service delivery and financing. Through waivers, states can design and demonstrate various approaches to reforming child welfare and improving safety, permanency, and well-being outcomes.

it has not yet made foster care receiving homes available. Reinstituting the use of these homes would allow more children to be placed in family settings rather than emergency shelters.

Finally, the Department should monitor and assess the outcomes of its efforts to reduce the use of congregate care and make adjustments as needed.

Recommendations:

1.1. The Department should continue to assess what actions it can take to appropriately reduce the number of children entering out-of-home care.

1.2. The Department should develop and implement a comprehensive approach to reduce the use of congregate care in Arizona. In developing this approach, the Department should consider various strategies, such as those used in other jurisdictions, that address the causes for increased congregate care use identified in this report and/or through its own analyses, such as:

- Continuing to look for ways to improve the recruitment and retention of foster families;
- Developing improved practices to establish permanency, including minimizing the use of independent living and long-term foster care as permanency goals and increasing permanency planning activities such as permanency roundtables;
- Instituting policy changes that would restrict the use of congregate care, such as requiring preauthorization for placing a child in congregate care or prohibiting its use for young children;
- Developing performance-based contracts to identify and eliminate poorly performing congregate care service providers; and
- Working with providers to improve the provision, array, and coordination of evidence-based services, including behavioral health services.

1.3. The Department should establish a plan and time frame for reinstituting the use of foster care receiving homes, which the Legislature has appropriated it funding to do.

1.4. The Department should monitor and assess the outcomes of its efforts to reduce the use of congregate care and make adjustments as needed.

APPENDIX A

This appendix summarizes reported information on how other jurisdictions planned and/or implemented solutions to reduce congregate care use in their jurisdictions.

Examples of other jurisdictions' efforts to reduce congregate care use

Tennessee

According to studies on the Tennessee Department of Children's Services' (Department) reform efforts, the impetus for reducing the use of congregate care was a class action lawsuit settled in 2001.[1] The lawsuit alleged, among several deficiencies in the child welfare system, that the Department routinely placed children in congregate care settings when it was not in their best interests. For example, children were allegedly placed in overcrowded emergency shelters and stayed in temporary placements for months at a time, and the supply of foster homes was inadequate. Further, many foster families were allegedly not well prepared to meet the behavioral and emotional needs of children placed in their care. The resulting settlement agreement required the Department to take multiple actions regarding its use of congregate care, and a technical assistance committee was created to provide oversight and guidance during the reform process. Some specific reforms the Department implemented included:

- **Development of a foster home recruitment and retention plan**—To successfully move children out of congregate care and prevent children from unnecessarily entering congregate care, the Department needed to ensure that it had a sufficient number of foster homes. The Department revised its recruitment strategy to find foster homes for teenagers and children with special needs. Additional training, including therapeutic training, was provided to foster parents to ensure they were prepared to meet the needs of children in their care.

- **Implementation of a validated child assessment tool**—The Department adopted and trained staff on a validated assessment tool, the Child and Adolescent Needs and Services (CANS). This tool helps to ensure each child is placed in the least restrictive environment based on the intensity of service needed by that child.

- **Establishment of enhanced staff training**—The Department partnered with universities to develop and administer new pre-service and in-service training for employees. The new training focused on understanding the negative effects of congregate care and institutionalization, barriers to permanency related to congregate care placement, and the importance of children living in family settings.

[1] All information on Tennessee's reform efforts is a summary of the following sources: Alpert, L.T., & Meezan, W. (2012). Moving away from congregate care: One state's path to reform and lessons for the field. *Children and Youth Services Review*, 34, 1519-1532 and Children's Rights. (2011). *What works in child welfare reform: Reducing reliance on congregate care in Tennessee*. New York, NY: Author.

- **Institution of a utilization review process—**To improve administrative oversight, the Department instituted a utilization review process that allows administrators to monitor cases to make certain children are moving toward permanency. Although all cases are subject to utilization review, stakeholders noted that the process was particularly useful for children placed in group care.

- **Implementation of policies to limit entry and length of stay in congregate care—**The settlement required the Department to revise its polices, including requiring administrative approval before placing a child in a group setting that has eight or more beds, prohibiting placing children under the age of 6 in group facilities except under extraordinary circumstances, and limiting shelter stays to 30 days. The Department also instituted a policy requiring a psychologist's permission to place a child into congregate care.

- **Closure of congregate care housing—**The Department closed its large public congregate care facility that housed over 300 children at the time of the lawsuit, most of whom were older and did not appear to need the services provided in a congregate care setting. Partnering with Vanderbilt University, the Department asked for children's input into potential placement settings. Specifically, the Department asked youth about their community connections and if they knew someone with whom they could live. The children often identified adults who were viable resources, and many children were able to move out of congregate care into a family-based setting.

- **Engagement of children and families in placement and case planning—**The Department also instituted Child and Family Team Meetings, a practice model that brings together individuals who are connected to a child with the purpose of working as a team to develop and monitor a case plan that will maximize safety, permanence and well-being for the child. The model emphasizes family strengths and use of community resources.

- **Restructuring of contracts—**The Department instituted a "continuum model" and moved to performance-based contracting for services to improve outcomes and incentivize providers. The continuum model requires contract providers to maintain placement options along the foster care continuum (e.g., residential treatment facility, group home, treatment foster care, in-home services, and adoption services), rather than just residential care.[1] Not all providers were willing or able to make this change, and, eventually, they no longer contracted with the Department. A key attribute of the model is paying providers at the same rate no matter where they place a child. Because congregate care is more expensive than providing services in a foster home, providers are incentivized to save money under the continuum model by placing children with families. Additionally, the Department's performance-based contracting program rewards providers for three main outcomes: (1) decreasing length of stay, (2) increasing permanent exits (e.g., reunification, adoption, or guardianship), and (3) reducing reentries into foster care.

- **Development of a new information system—**The Department developed an enhanced information system that provides information on where children are living on any given day,

[1] According to the U.S. Department of Health and Human Services' Child Welfare Information Gateway, treatment (or therapeutic) foster care is designed to provide safe and nurturing care to a child in a more structured home environment than typical foster care and can be a cost-effective alternative to residential treatment.

as well as information on placement types and placement history. This added capacity allowed administrators to see where and at what frequency regions were using congregate care. Administrators then provided technical assistance to help high congregate care regions reduce their reliance on congregate care.

Reported results—As a result of changes the Department made in its out-of-home care system, the percentage of children in out-of-home care that were in congregate care decreased from 22 percent in January 2001 to 9 percent in January 2009. The continuum model successfully allowed providers to serve children with complex needs in family settings while controlling the high cost of congregate care. As of 2009, it had exceeded department goals, serving 95 percent of all moderately disturbed children and 75 percent of severely disturbed children in family settings.

Maine

A case study in public child welfare reform in three jurisdictions—Maine, New York City, and Virginia—indicated that prior to reform, Maine's Office of Children and Family Services (Office) had a bias against placement with relatives, and, as a result, children were placed far from their homes and communities and could be placed out of state[1]. Working with a consultant, the Office developed a goal of moving 10 percent of children in congregate care to permanent, home-based placements. Specifically, the Office:

- **Developed policies that made it more difficult for caseworkers to place and keep children in congregate care—**The Office instituted a policy that required prior authorization for a child to be placed in congregate care. It also instituted a utilization review process for ongoing institutional placements.

- **Established a performance monitoring system to ensure congregate care reduction goals were met and to enhance accountability—**The Office's director established a performance tracking system and personally monitored the congregate care census for each region on a weekly basis. Regional directors were held accountable at monthly staff meetings, and leaders who did not support efforts to reduce congregate care were removed. Over time, the state expanded its performance management by adding outcome measures for supervisors and caseworkers. In addition, providers were offered an incentive to change the services they provided to reflect the Office's new focus on permanency.

- **Revised its staff training around permanency and established permanency teams—**The Office completely revised its training to reflect the updated mission and practice, and established permanency teams that worked with children and families to help move children out of congregate care.

- **Shifted funding to wraparound and community-based services—**Eventually, $4 million was shifted from congregate care placements to family "wraparound" and community-based

[1] All of the information on Maine's, New York City's, and Virginia's reform efforts is a summary of the following source: Menashi, D., Behan, C., & Noonan, K. (2012). Helping government agencies become more effective and efficient: Discovering 'catalytic combinations' in public child welfare reform. *The Foundation Review*, 4(1).

services.[1,2] The state reportedly continues to invest in developing an array of community-based services and has instituted evidence-based practices.

Reported results—According to the case study, the Office reduced its congregate care use by 8 percent in the first 6 months, and by 46 percent within 2 years. As of July 2011, only 5 percent of foster children were in institutional settings.

New York City

According to the case study noted earlier, the New York City Administration for Children's Services' (Administration) reform efforts focused on reducing congregate care placements for teenagers by reducing the supply of congregate care beds.[3] Specifically, the Administration:

- **Leveraged performance data to identify and eliminate poorly performing congregate care providers—**The Administration had a performance measurement system that it used to determine how quickly congregate care providers moved children into stable alternative or permanent placements. This performance data allowed it to make decisions about which providers should be eliminated because of poor performance.

- **Implemented a new practice of engaging teenagers to find family-based placements—**To ensure teenagers living in closing congregate care facilities were transitioned to family-based placements, the Administration designed a new case review process. Teams of social workers interviewed teenagers to explore permanency options based on existing adult connections. Caseworkers then contacted these adults to explore the possibility of providing permanency for the teenagers. In addition, teenagers were encouraged to consider open adoption that permitted contact with their birth families, which was important to teens who did not want their parents' rights severed.

- **Subsequently changed policy related to congregate care use—**The Administration changed its policy to require supervisory approval for congregate care placement.

Reported results—According to the case study, closing beds was a successful strategy. During the summer of 2003, 11 agencies voluntarily closed 169 beds and transferred as many as 40 percent of teenagers to family-based settings; within 1 year, the goal of eliminating 600 beds was met. As of 2011, contracted beds had been reduced from 4,174 beds in 2002 to 1,440 beds. In addition, congregate care trends reversed from approximately two-thirds of teenagers being placed in congregate care in 2003 to one-third of teenagers being placed in congregate care by 2006.

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[1] The National Wraparound Initiative defines wraparound as an intensive, individualized care planning and management process of engaging individuals with complex needs (typically children, youth, and their families). Wraparound is not treatment, but rather a process that achieves positive outcomes through a structured, creative, and individualized team planning process that allows children to remain in their homes and communities.

[2] The U.S. Department of Health and Human Services, Administration for Children & Families, Child Welfare Information Gateway defines community-based services as high-quality services accessible to families in the least restrictive setting possible. Community-based services help keep children in their families and communities.

[3] Menashi, Behan, & Noonan, 2012

Virginia

According to the case study noted earlier, Virginia's newly elected governor used a fundamental push to reduce congregate care to drive change throughout its locally administered child welfare system for which the state has oversight.[1] Initially, Virginia took specific actions in finance and frontline practice, but has continued to enhance services. Specifically, Virginia:

- **Piloted new approaches to placement decisions—**The state piloted Team Decision Making in Richmond as part of its efforts to reduce the number of congregate care placements and to improve family engagement. The state also piloted a placement process in which staff met with 17-year-olds to discuss moving from a group home to a family-based setting. Within weeks, half of the group were able to move into a family-based setting, and another 15 percent had plans to move within 60 days. The state also engages families using a family-engagement teaming process before a child enters foster care.

- **Changed the way the state funded foster-care placements—**Funding was driving placements at the local level, so the state adjusted reimbursements to localities by having a lower match rate for congregate placement and a higher match rate for community-based services that allowed children to stay in their own homes. This created an immediate financial disincentive for localities and providers because, across the state, one-third of all children, and in Richmond, half of all children, were in a congregate care setting at the time of the initiative.

- **Enhanced services—**In addition, the state made investments in recruitment, development, and support of resource families and created a continuum of community-based services.

Reported results—According to the case study, Virginia made additional progress in Richmond, and, within 2 years of the starting its initiative, the number of children in foster care went from 548 to 388, and the number of children in congregate care from 282 to 71. State-wide reform led to improvements in exits from the system to permanency, which increased from 64 percent to 73 percent from 2007 to 2010. Further, after years of cost increases, the state decreased its spending on congregate care and community-based spending by 6 percent, saving more than $100 million compared to projected costs.

Connecticut

According to its 2011 report on efforts to rightsize and redesign congregate care, Connecticut's Department of Children and Families (Department) wanted to reduce congregate care use.[2] Other goals included reviewing and repurposing therapeutic group homes and implementing a system of performance management. Specifically, actions the Department planned or that were in progress included:

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[1] Menashi, Behan, & Noonan, 2012

[2] All of the information on Connecticut's reform efforts is a summary of the following source: Connecticut Department of Children and Families. (2011). *Congregate care rightsizing and redesign: Young children, voluntary placements and a profile of therapeutic group homes.* Hartford, CT: Author.

- **Enhancing frontline practice and training—**The Department was continuing its efforts to implement the Strengthening Families Practice Model state-wide.[1] In addition, the Department was partnering with higher education and the private sector to provide joint training for staff, foster families, and providers on various topics, such as family-centered care and trauma-informed practice. The Department was also adopting new procedures to better manage the length of stay in therapeutic group homes.

- **Improving services—**The Department was planning to increase its use of foster families and kinship care. In addition, it planned to take steps to ensure appropriate support to biological, adoptive, and foster families using evidence-based wraparound service models. Further, the Department planned to establish guidelines for services provided by therapeutic group homes and identify services that could be delivered in the community.

- **Developing and implementing performance management strategies—**The Department planned to implement a performance management system. Planned actions included establishing performance outcomes, criteria, measures, and timelines related to keeping children in families and moving children out of congregate care; building capacity for enhanced data use; and developing a monitoring system for congregate care providers.

- **Revising policy requirements for congregate care placements—**The Department planned to implement policy changes to help ensure that children ages 12 and younger were served in family-based settings and that children 6 years and younger were not placed in congregate care without the department commissioner's approval.

Reported results—This report discussed planned efforts to reduce congregate care use and, therefore, did not address the results of these efforts.

[1] The Strengthening Families Practice Model incorporates a focus on family strengths and protective factors. Connecticut's core elements include family-centered practice, purposeful visits, family assessment, and a family teaming model of engagement.

APPENDIX B

This appendix lists information sources cited in this report, including peer-reviewed journal articles and research, best practice, and other publications. Topics include appropriate congregate care use, effects of congregate care placement on children, best practices in foster care for children and families, studies on foster family retention in Arizona, and strategies other jurisdictions used to minimize congregate care use.

Works cited

Alpert, L.T., & Meezan, W. (2012). Moving away from congregate care: One state's path to reform and lessons for the field. *Children and Youth Services Review*, 34, 1519-1532.

Annie E. Casey Foundation. (2013). *Reconnecting child development and child welfare: Evolving perspectives on residential placement*. Baltimore, MD: Author.

Annie E. Casey Foundation. (2013). *When child welfare works: A working paper* [A proposal to finance best practices]. Baltimore, MD: Author.

Annie E. Casey Foundation. (n.d.). *Case Practice Standards Manual*. Baltimore, MD: Author.

Arizona State University, College of Public Programs, School of Social Work. (2014). *Voluntary closure study: Former foster care families in Arizona*. Tempe, AZ: Author.

Barth, R.P. (2002). *Institutions vs. foster homes: The empirical base for a century of action*. Chapel Hill, NC: UNC, School of Social Work, Jordan Institute for Families.

Children's Rights. (2011). *What works in child welfare reform: Reducing reliance on congregate care in Tennessee*. New York, NY: Author.

Connecticut Department of Children and Families. (2011). *Congregate care rightsizing and redesign: Young Children, voluntary placements and a profile of therapeutic group homes*. Hartford, CT: Author.

Feild, T. (2012). *Congregate care rightsizing: What's best for kids is also good for state budgets*. Baltimore, MD: Annie E. Casey Foundation, Child Welfare Strategy Group.

Freundlich, M. (2010). *Legislative strategies to safely reduce the number of children in foster care*. Denver, CO: National Conference of State Legislatures.

Freundlich, M., & Avery, R.J. (2005). Planning for permanency for youth in congregate care. *Children and Youth Services Review*, 27, 115-134.

Geiger, J.M., Hayes, M.J., & Lietz, C.A. (2013). Should I stay or should I go? A mixed methods study examining the factors influencing foster parents' decisions to continue or discontinue providing foster care. *Children and Youth Services Review*, 35, 1356-1365.

Lee, B.R., Bright, C.L., Svoboda, D.V., Fakunmoju, S., & Barth, R.P. (2011). Outcomes of group care for youth: A review of comparative studies. *Research on Social Work Practice*, 21(2), 177-189.

Menashi, D., Behan, C., & Noonan, K. (2012). Helping government agencies become more effective and efficient: Discovering 'catalytic combinations' in public child welfare reform. *The Foundation Review*, 4(1), Art. 3.

Murphy, A.L., Van Zyl, R., Collins-Camargo, C., & Sullivan, D. (2012). *A*ssessing systemic barriers to permanency achievement for children in out-of-home care: Development of the child permanency barriers scale. *Child Welfare*, 91(5), 37-71.

Noonan, K., & Menashi, D. (2010). *Rightsizing congregate care: A powerful first step in transforming child welfare systems*. Baltimore, MD: Annie E. Casey Foundation.

North American Council on Adoptable Children. (2005). *A family for every child: Strategies to achieve permanence for older foster children and youth*. (Family to family: Tools for rebuilding foster care). Baltimore, MD: Annie E. Casey Foundation.

Ryan, J.P., Marshall, J.M., Herz, D., & Hernandez, P.M. (2008). Juvenile delinquency in child welfare: Investigating group home effects. *Children and Youth Services Review*, 30, 1088-1099.

Sudol, T. (2009). *Placement stability information packet*. New York, NY: National Resource Center for Permanency and Family Connections, Silberman School of Social Work at Hunter College, City of New York University.

APPENDIX C

This appendix provides information on the methods auditors used to meet the report objectives. The Auditor General and staff express appreciation to the Arizona Department of Child Safety (Department) Director and staff for their cooperation and assistance throughout the engagement.

Methodology

Auditors used the following methods to meet the report objectives:

- Auditors interviewed department management and staff and reviewed congregate care provider contract templates, applicable department policies and procedures, applicable federal and state laws, department reports, other information obtained from the Department, prior Office of the Auditor General reports, and the January 2014 Child Advocate Response Examination (CARE) Team Report to the Governor.[1]

- Auditors conducted the following analyses:

  - Analyzed information obtained from the Department's Children's Information Library and Data Source (CHILDS) data system on the Arizona children placed in out-of-home care as of September 30, 2013.[2]

  - Analyzed financial information on emergency and residential placement expenditures from the CHILDS *Report 87* for fiscal years 2009 through 2013.

  - Analyzed information from the Department's semi-annual child welfare reports for the periods ended September 30, 2009 through March 31, 2014, regarding the number of children in out-of-home care, the number of licensed foster homes, and reasons for foster home license closure.[3]

[1] The CARE Team was created by the Governor in response to the revelation in November 2013 that department staff intentionally did not investigate nearly 6,600 child abuse and neglect reports. The CARE Team was tasked with overseeing the investigations of these cases; assessing department policies, procedures, and personnel; and making recommendations for change.

[2] Based on prior audit work and limited data testing, auditors determined that the CHILDS data was sufficiently reliable for the purposes of this report.

[3] Information in the semi-annual reports is compiled from department data systems, including CHILDS. Based on a review of the Department's processes for compiling this information, auditors determined that the information auditors analyzed was sufficiently reliable for the purposes of this report.

- Analyzed national data on children in out-of-home care from the Adoption and Foster Care Analysis and Reporting System (AFCARS) for October 2009 through September 2012 (federal fiscal years 2010 through 2012).[1,2]

- Analyzed information on out-of-home care placements from analyses of department CHILDS data performed by Chapin Hall, a research and policy center at the University of Chicago, for January 2009 through December 2013.

- Auditors reviewed literature related to the appropriate use of congregate care, effects of congregate care placement on children, best practices in foster care for children and families, studies on foster family retention in Arizona, and strategies other jurisdictions used to minimize congregate care use (see Appendix B, pages b-1 through b-2). In addition, auditors interviewed experts from Chapin Hall and the University of Louisville.

- Auditors reviewed case files for two children in congregate care to determine factors contributing to their being placed in congregate care.

- Auditors interviewed staff from four congregate care providers, of which two are also child-placing agencies, regarding factors contributing to the placement of children in congregate care settings.

[1] AFCARS is a federally mandated data collection system into which states must submit data on their respective foster care systems to the Children's Bureau of the U.S. Department of Health and Human Services' Administration on Children, Youth, and Families. The Children's Bureau provides AFCARS data annually to the National Data Archive on Child Abuse and Neglect (NDACAN) at Cornell University for distribution to interested parties. The AFCARS data used in this report was made available by NDACAN and has been used by permission. Neither the collector of the original data, the funder, NDACAN, Cornell University, or its agents or employees offer any assurance or accept any responsibility for the accuracy or comprehensiveness of the data provided or bear any responsibility for the analyses or interpretations presented here.

[2] Based on auditors' review of the Children's Bureau's data reliability assessment process, auditors determined that AFCARS data was sufficiently reliable for the purpose of this audit.

AGENCY RESPONSE

Arizona Department of Child Safety

Janice K. Brewer
Governor

Charles Flanagan
Director

October 8, 2014

Ms. Debra K. Davenport
Office of the Auditor General
2910 North 44th Street, Suite 410
Phoenix, Arizona 85018

Re: Auditor General Congregate Care Audit Response

Dear Ms. Davenport:

The Arizona Department of Child Safety (Department) appreciates the opportunity to provide this response to the Auditor General's report on Congregate Care Placements.

The Department values the collaborative effort of the Auditor General's staff throughout this audit. In general, the recommendations are constructive in helping the Department better serve the children in our care. Currently, there are over 16,000 children in out of home care in Arizona. The Department remains committed to reducing the use of congregate care settings. The Department agrees that we should continue to assess actions that lead to a reduction of children in out-of home care and implement a comprehensive approach to reducing congregate care placements.

As noted by the Auditor General, the Department has taken actions to reduce the usage of congregate care. Specifically:

- **Federal approval on demonstration project**. On September 30, 2014, the Children's Bureau approved the Department's Title IV-E Waiver Demonstration Proposal. The focus of our demonstration project was selected to "right size and redesign" the current congregate care system. Data has shown an increase in its use and there was consensus that more family-like placements are better at meeting the needs of the vulnerable children we serve. All aspects of congregate care will be thoroughly analyzed and researched in an effort to examine why congregate care use has increased, and the most promising opportunities for reducing its use. Ultimately we want to change agency culture by generating critical thinking about using congregate care and the length of time for which it is used.

- **Implementation on differential response**. A Differential Response system constitutes a new approach in working with families that receive low risk maltreatment reports without compromising child safety. The Department is committed to the creation of a Family

Assessment Response, a second pathway for reports of maltreatment, as this supports the vision of expanding prevention and early intervention treatment and services.

- **Improved recruitment and retention of foster care parents**. To better understand and address foster parent retention, the Department commissioned a survey on foster home closure and foster parent retention. The Department has also partnered with faith-based groups to support church members engaged in foster care and adoption.

- **Improved contracting practices.** To improve recruitment, training and retention of foster parents, the Department will issue a performance-based contract for its foster home recruitment services in early 2015. The contract will include performance measures, performance guarantees and vendors will be monitored for compliance with terms and conditions.

We believe the Department's efforts will help maintain the momentum needed to create our new child welfare agency. Transforming the congregate care system directly aligns with, and will influence, our broader agency transformation goals and will be another mechanism to improve outcomes for children and families.

RECOMMENDATIONS – CHAPTER 1

1.1 The Department should continue to assess what actions it can take to appropriately reduce the number of children entering out-of-home care.

1.2 The Department should develop and implement a comprehensive approach to reduce the use of congregate care in Arizona. In developing this approach, the Department should consider various strategies, such as those used in other jurisdictions, that address the causes for increased congregate care use identified in this report and/or through its own analyses, such as:

- Continuing to look for ways to improve the recruitment and retention of foster families;
- Developing improved practices to establish permanency, such as minimizing the use of independent living and long-term foster care as permanency goals and increasing permanency planning activities;
- Instituting policy changes that would restrict the use of congregate care, such as requiring preauthorization for placing a child in congregate care or prohibiting its use for young children;
- Developing performance-based contracts to identify and eliminate poorly performing congregate care service providers; and
- Working with providers to improve the provision, array, and coordination of evidence-based services, including behavioral health services.

1.3 The Department should establish a plan and time frame for reinstituting the use of foster care receiving homes, which the Legislature has appropriated it funding to do.

1.4 The Department should monitor and assess the outcomes of its efforts to reduce the use of congregate care and make adjustments as needed.

Response:

The finding of the Auditor General is agreed to and the recommendations will be implemented.

Thank you again for the opportunity to provide feedback. We value the time, effort, and diligence of the Auditor General's staff in producing this report.

Sincerely,

Charles Flanagan
Director

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13-14	Review of Selected State Practices for Information Technology Procurement
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Future Performance Audit Division report

Arizona Department of Administration—Arizona State Purchasing Cooperative Program