TIME RUNNING OUT:

TEENS IN FOSTER CARE

CHILDREN’S RIGHTS
JUVENILE RIGHTS DIVISION
OF THE LEGAL AID SOCIETY
LAWYERS FOR CHILDREN
TIME RUNNING OUT: Teens in Foster Care

Madelyn Freundlich

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Children’s Rights
Juvenile Rights Division of The Legal Aid Society
Lawyers for Children
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EXECUTIVE SUMMARY

This study focuses on the experiences of and outcomes for youth in congregate care in the New York City foster care system. It examines issues that affect young people ages 12 and older in group homes, residential treatment centers, maternity facilities, and mother/child facilities in the five boroughs of the City. Jointly undertaken by Children’s Rights, the Juvenile Rights Division of The Legal Aid Society, and Lawyers for Children, it addresses concerns that originally were identified in a class action lawsuit brought against the City’s public child welfare agency, the Administration for Children’s Services (ACS). These concerns also were a focus in a series of reports issued by a panel of national child welfare experts convened after the lawsuit was settled. This study – which was carried out with support from The Robert Sterling Clark Foundation, Alice Rosenwald, The Annie E. Casey Foundation, The Jim Casey Youth Opportunities Initiative, New York Community Trust, The DeCamp Foundation, The Hite Foundation, and Roche Relief Fund – was conducted with the cooperation of ACS.

The study examined issues in six substantive domains through a qualitative research design:

1) Placements for youth who enter foster care. The issues in this domain included the extent to which congregate care is used as a placement option for youth; perceptions regarding the appropriateness of congregate care as a placement resource for youth in care – both in general and with regard to special populations; and the factors associated with the quality of congregate care placements.

2) Services for youth in congregate care. Included in this domain were issues regarding the overall quality of services for youth in congregate care and the extent to which youth need and have access to specific services, particularly educational services, physical and mental health services, substance abuse treatment, legal services, and youth development services.

3) Safety in congregate care. These issues included the extent to which youth are physically safe in congregate care settings; the safety of their personal belongings in these settings; the physical conditions of congregate care settings; and the safety of the neighborhoods and communities in which congregate care facilities are located.

4) Permanency for youth in congregate care. Included in this area were the overall quality of permanency planning for youth in congregate care, the extent to which different permanency goals (reunification, adoption, and independent living) are utilized for this population of youth; and perceptions of the appropriateness of different permanency goals for these youth.

5) Youth involvement in planning and decision-making. The key issue in this domain was the extent to which youth have meaningful opportunities to participate in planning and decision-making with regard to issues that personally affect them.

6) Transitioning from foster care. These issues included the overall quality and effectiveness of efforts to prepare youth to leave foster care, particularly when they have a permanency goal of independent living; and the outcomes for youth who leave foster care, particularly when discharged to independent living. Specifically, the study explored outcomes related to health care, housing, education, employment, personal connections and supports, access to needed papers, and immigration/legal status.
The individuals who were interviewed also were asked to identify what is working well for youth in the New York City foster care system; whether there are aspects of the system that are not working well for youth; and if so, the specific changes that are needed so that youth are more effectively served.

Interviews were conducted with two primary groups of stakeholders: young adults who had been in foster care and had been placed in congregate care settings and professional stakeholders. The professionals stakeholders who were interviewed were: family court judges (including one referee); representatives of private child welfare agencies that provide congregate care; attorneys who represent youth in the foster care system; social workers; and representatives of New York City advocacy organizations with expertise on issues that impact youth in foster care. In addition, individual and group interviews were conducted with representatives of ACS whose roles and responsibilities were relevant to the study's areas of focus. Finally, two focus groups were held with young adults to further explore their views of what “works” and does not “work” in the foster care system for youth and what changes are needed.

One key component of the study was a literature review that encompassed national and New York City research. This review was conducted to document the current knowledge base on the issues on which the study focused. Although the literature was found to be fairly extensive in some areas (such as youth's transitions from foster care and youth's needs for mental health and educational services), there were obvious gaps in the literature in other areas – including the extent to which congregate care is an appropriate placement option for youth; the safety of youth in foster care, in general, and in congregate care, in particular; and youth involvement in planning and decision-making. This study builds on the existing knowledge base and further enriches it by addressing issues that previously have received only limited attention.

**FINDINGS**

Although different views were expressed within each group of stakeholders, the professionals and the young adults who were interviewed demonstrated a high level of agreement on many of the questions that were explored. Among the key findings from the interviews with the young adults and professional stakeholders were the following:

**Placements for Youth in Congregate Care**

1) In general, congregate care does not work well for youth as it does not provide a “family-like” setting and fails to meet the service and permanency needs of youth.

2) The quality of current congregate care settings for youth is extremely variable with facilities being, in the words of one respondent, “a mixed bag.”

3) The quality of staff is critical to the quality of congregate care placements but is frequently quite poor.

**Services for Youth in Congregate Care**

1) Quality services for youth in congregate care generally are not readily available.

2) There is a lack of focus on education for youth in congregate care. In particular, there are problems with the inappropriate use of on-site educational programs for youth in Residential
Treatment Centers and difficulties ensuring youth's enrollment in and attendance at public schools when they are placed in group homes.

3) Mental health services are seriously lacking for youth in foster care, in general, and youth in community-based group homes, in particular.

**The Safety of Youth in Congregate Care**

1) Youth often are not personally safe in congregate care settings as a result of peer-on-peer violence and gang-related activity.

2) Stealing of youth's belongings is a pervasive problem in congregate care.

3) Safety for youth is closely tied to having a sufficient number of adequately trained staff.

**Permanency for Youth in Congregate Care**

1) Overall, the quality of permanency planning is poor for youth in congregate care.

2) Reunification of youth with their parents is undermined by the failure of congregate care facilities to work closely with families and encourage parent-youth visits. At least one key factor working against reunification is that youth often are placed at geographic distances from their families.

3) Inadequate attention is given to identifying extended family members and other caring adults who can be permanent resources for youth in congregate care.

**Youth Involvement**

1) Youth are not adequately involved in planning and decision-making on matters that directly affect them.

2) Youth involvement in Service Plan Reviews (SPRs) is very limited.

3) Youth generally are not given opportunities to participate at court hearings regarding their cases.

**Transitioning from Care**

1) Youth are not being adequately prepared to transition from foster care to living independently as adults.

2) Housing is particularly problematic for youth who leave care with a goal of independent living.

3) Youth who age out of foster care at age of 18 (or older in some cases) are educationally disadvantaged and that limitation has a significant impact on their success as adults.

Of note was the finding across all of the substantive domains that individual staff members at congregate care facilities could and did, in many cases, make a significant difference in youth's lives – that is, they ensured that youth had the services they needed, they made the young people feel safe in the group or residential care setting, they prepared youth for life after discharge from foster care, and they listened to the youth's needs and wishes. This finding made clear that despite the marked deficiencies that were repeatedly reported, quality staffing and services are indeed achievable when youth must be placed in congregate care settings.
RECOMMENDATIONS

The findings from the study made clear that changes in the foster care system in New York City are needed in three major areas:

Recommendation #1: ACS must reduce its reliance on congregate care and develop family-based placements for youth in foster care.

Emphasis must continue to be placed on significantly reducing the number of youth who are placed in congregate care settings in the New York City foster care system. Efforts must focus on recruiting and supporting foster families for youth in care.

- Recruitment must focus on identifying families who want to care for teens, who enjoy working with teens, and who have experience parenting teens.
- Foster families with whom teens are placed must be provided with enhanced financial and service supports.
- Casework practice must be changed so that caseworkers recognize the value of family for teens.

Recommendation #2: ACS must redesign congregate care so that it functions as a service-based, family-like model that ensures the safety and well-being of youth.

To the extent that congregate care is used as a placement resource for youth whose special needs require this level of care, it must be substantially transformed – that is, the current group residence model with its focus on behavior control must be replaced with a service-based, family-like model.

- Congregate care facilities must be safe environments for youth in care.
- The staff of congregate care facilities must be appropriately screened, trained, and supervised so that they provide youth with the structure, support, and guidance that they need.
- Youth in congregate care must be thoroughly prepared to transition from care to life outside the foster care system.

Recommendation #3: ACS and the private agencies that provide congregate care must be held fully accountable for the outcomes that are – and are not – achieved.

ACS must exert significantly greater control over the provision of congregate care and hold both itself and the private agencies that provide congregate care fully accountable for the outcomes that are – and are not – achieved. ACS must:

- Develop contracts with private agencies that include outcome measures that are specific to the needs of youth in congregate care.
• Monitor agencies’ performance on outcome measures.
• Use data measuring outcome achievement and performance to make decisions regarding continuation of contracts with private agencies.

These steps must be taken to address the critical issues that this study identified. Absent significant improvements in the foster care system, youth in care will continue to experience threats to their safety and well-being, will lack permanent family connections, and will continue to age out of foster care without the support and services that are vital to a successful adulthood.
This study focuses on the experiences of and outcomes for youth in congregate care in the New York City foster care system. Its emphasis on youth – young people ages 12 and older – and on group and residential care placements reflect ongoing concerns of the study’s sponsors – Children’s Rights, the Juvenile Rights Division of The Legal Aid Society (JRD) and Lawyers for Children (LFC).

In December 1995, Children’s Rights and Lawyers for Children filed a lawsuit on behalf of children and youth in foster care against the New York State Office of Children and Family Services (OCFS) and the New York City Administration for Children Services (ACS) [then known as the Child Welfare Administration]. That lawsuit alleged a number of serious problems with the child welfare system in New York City (the City), including problems related to placements and services for youth in foster care. In December 1998, the lawsuit was settled, and the City agreed to utilize the expertise of independent outside child welfare experts to guide it in undertaking the systemic reforms that were necessary. An expert advisory panel was convened and was granted complete access to all aspects of ACS’ operations. The panel assessed the strengths and weaknesses of the City’s child welfare system and made recommendations to improve the quality of child welfare services. The panel’s work concluded with a final report in December 2000 which praised the City for its accomplishments in revamping the child welfare system but also noted that much more work was needed to ensure that the system worked effectively on behalf of children and youth and their families (Special Child Welfare Advisory Panel, 2000).

Among the issues that the panel’s report identified as warranting greater attention was services to youth and their families. The panel recommended that greater attention be given to the preventive services, foster family resources, and “wraparound” services needed by youth and their families; that focus be placed on the “most troubled” congregate care sites at which youth were placed; and that ACS increase its oversight of congregate care facilities (Special Child Welfare Advisory Panel, 2000, p. 32). In its report, the panel (2000, p. 33) went on to note that needed changes included:

…the identification of foster families able to meet the challenges of caring for adolescents, including those who can meet special needs such as those of mothers with babies and gay or lesbian teens…

[and greater efforts to meet] the comprehensive service needs of adolescents and their parents, in such diverse areas as more quickly enrolling teens in school and better addressing their educational needs; better involving them in the development and review of their own service plans; improving access to counseling and support services; and strengthening preparation for independent living.”

The panel also focused on the need for greater involvement and engagement with the families of adolescents, with attention to supporting youth’s continuing connections with their families, including both parents and siblings; the need to focus on permanency for all children and youth in care; and the need to carefully assess “the respect with which youth are treated, even when they are difficult and challenging” (Special Child Welfare Advisory Panel, 2000, p.49). The panel recommended, as one of the key benchmarks that ACS should attain, that the agency address the strengths and weaknesses of the current system in meeting the needs of adolescents and their families and identify the most significant changes in policies, procedures, training, and services required to better meet those needs (Special Child Welfare Advisory Panel, 2000, p.32).
Children’s Rights, JRD, and LFC also have had ongoing concerns about youth in foster care in New York City – their safety, their well-being, and the extent to which permanency is being achieved for teens. In 2002, the three organizations met to consider how, in light of the panel’s report and concerns, they could promote improvements in the City’s provision of foster care services to youth, particularly youth in congregate care. The organizations made the decision to implement a comprehensive study of the experiences of and outcomes for youth in congregate care in New York City to determine what was “working” and “not working” for these youth. They worked together to develop a research approach that would enhance the understanding of the experiences of youth placed in group and residential care settings, the outcomes that are being achieved for these youth, and the policy and practice areas where greater attention needed to be focused to ensure that youth have positive experiences in care and achieve positive outcomes. The study was designed to gather and analyze information that could support the development of specific, practical recommendations that the organizations could make to ACS to support its efforts to improve foster care for youth.

This report provides the results of that study and the recommendations that emerged from the findings. First, the focus and methodology of the study are detailed. Then, the current knowledge base – in terms of the research literature – is presented. This section of the report sets the context for understanding the findings of this study by drawing on national and local data, child welfare literature and research, and studies that have been conducted in New York City and that address issues that impact youth in foster care. The next section of the report summarizes the findings from interviews with two groups: (1) interviews with adult stakeholders – judges, law guardians, social workers, representatives of private child welfare agencies that provide congregate care, and representatives of advocacy and other relevant organizations that focus on issues that impact youth in foster care; and (2) interviews with young people who were placed in congregate care settings while in foster care. The report then discusses these findings and makes recommendations designed to improve the experiences of and outcomes for youth in foster care in New York City. The report concludes with observations about the important lessons learned from this study.
This qualitative study of the experiences of and outcomes for youth in congregate care in New York City focused on youth ages 12 and older whose experiences in foster care involved congregate care placements. For purposes of the study, “congregate care” was defined as including the following:

- **Group homes.** New York State law defines a group home as a family style home for seven to twelve children who are at least five years old (New York State Social Service Law, Section 371(17)).

- **Residential Treatment Centers (RTCs).** A RTC is defined as an institution operated by or through a contract with a public child welfare agency (such as ACS) for children whose needs for services or supervision demand 24-hour residential care (18 New York City Compilation of Codes, Rules, and Regulations, 430.11(d)(4)).

- **Mother-child facilities.** A mother-child facility is a facility for the care and maintenance of not more than 10 mothers, who themselves are not children, and 10 babies of these mothers (18 New York City Compilation of Codes, Rules, and Regulations, 442.17).

- **Maternity facilities.** A maternity facility for purposes of this study is a residential facility for the care and maintenance of children under the care and custody of New York State and the City of New York who are pregnant. (see Child Welfare League of America, 1998, Standard 6.11).

Excluded from the definition of “congregate care” were: diagnostic centers (because of the temporary nature of their services) and Residential Treatment Facilities, (inpatient psychiatric treatment facilities operated by the New York State Office of Mental Health or the New York State Office of Mental Retardation in which care is provided under the direction of a physician to children who are under the age of 21) (14 New York City Compilation of Codes, Rules, and Regulations, 576.4(e)).

**Focus of the Study**

The study focused on six substantive domains related to the experiences of youth in congregate care: placements, services, safety, permanency, transitioning from care, and youth involvement in planning and decision-making. These domains – which represent important issues in congregate care – were derived from a consensus-building process drawing upon the research literature as well as the expertise of the Research Partners (Children's Rights, JRD and LFC). Specifically, the domains were:

1) Placements for youth who enter foster care. The issues explored in this domain included the extent to which congregate care is used as a placement option for youth; perceptions regarding the appropriateness of congregate care as a placement resource for youth in care – both in general and with regard to special populations; and the factors associated with the quality of congregate care placements.

2) Services for youth in congregate care. The issues explored in this domain included the overall quality of services for youth in congregate care and the extent to which youth need and have access to specific services such as educational services, physical and mental health care, substance abuse treatment, legal services, and youth development services.
3) The safety of congregate care. The issues explored in this domain included the extent to which youth are physically safe in congregate care settings; the safety of their personal belongings in these settings; the physical conditions of group homes and residential treatment centers; and the safety of the neighborhoods and communities in which congregate care facilities are located.

4) Permanency for youth in congregate care. The issues explored in this domain included the overall quality of permanency planning for youth in congregate care, the extent to which different permanency goals (reunification, adoption, and independent living) are being utilized for this population of youth; and perceptions of the appropriateness of different permanency goals for youth in care.

5) Youth involvement in planning and decision-making. The key issue explored in this domain was the extent to which youth have opportunities to participate in planning and decision-making on issues that personally affect them.

6) Transitioning from foster care. The issues explored in this domain included the overall quality and effectiveness of efforts to prepare youth to leave foster care, particularly when they have a permanency goal of independent living; and the outcomes for youth who leave care, particularly when discharged to independent living, with a focus on health care, housing, education, employment, personal connections and supports, access to needed papers, and immigration/legal status.

In addition, the study focused on the views of respondents regarding what currently is working well for youth in congregate care, whether there are aspects of the foster care system that should be changed in order to more effectively serve youth in care, and if so, the specific changes in the foster care system that are needed.

Methodology — Rationale for Using Qualitative Methods
The methodology was qualitative, involving in-depth individual and focus group interviews and following a “utilization-focused” evaluation approach (Patton, 2002, p. 173). The overall choice of a qualitative approach was based on an interest in understanding the insider perspectives of key stakeholders knowledgeable about the experiences of youth in congregate care. It was recognized that these individuals would have a wealth of personal and professional experiences as well as a wide range of opinions that could not be fully captured using standardized measures and quantitative analyses. Consequently, a qualitative methodology was chosen to provide a systematic, yet flexible way to capture and understand the rich diversity of views on complex and emotionally-charged issues associated with foster and congregate care.

The specific reliance upon “utilization-focused” evaluation methodology enabled the researchers to follow Patton’s recommendations for “creatively and flexibly interacting with intended evaluation users…taking into account the decision context in which an evaluation is undertaken” (2002, p. 175). By consulting and collaborating with key stakeholders throughout the study, the researchers sought to produce empirically grounded recommendations for practitioners, service providers, and policymakers that would be rigorous as well as accessible and applicable.
Research Design
The study design involved four components or phases: (1) the consensual development of domains of interest (i.e., salient issues) guiding data collection and analysis (described earlier); (2) the development and implementation of sampling and data collection protocols separately for the interviews and focus groups; (3) the use of content and theme analyses to identify patterns and summarize key findings within and across stakeholder groups; and (4) a reliance upon specified procedures for verifying and corroborating the study findings. Details on the study procedures are provided below.

1. In-Depth Individual Interviews
Sampling and Recruitment. The Research Partners identified six stakeholder groups to be interviewed using established protocols. These groups were: (1) family court judges and referees; (2) representatives of private child welfare agencies that provide congregate care for youth in foster care in New York City; (3) law guardians (the term used in New York City to refer to attorneys who represent children and youth in foster care); (4) social workers; (5) representatives of advocacy and other relevant organizations in New York City that focus on issues of importance to youth in foster care; and (6) young adults formerly in foster care who had been placed in group and residential care settings.

(a) Family court judges and family court referees. The Research Partners developed a list of family court judges and one referee who were perceived as having substantial experience in working with youth in foster care. The identified judges and referee represented all five boroughs of New York City. The Research Partners developed a letter explaining the study and the study's interest in interviewing family court judges and referees. The letter was provided to the Chief Administrative Judge for New York City courts, seeking his permission to contact the identified judges and referee to request their participation in the study. Permission was granted, and an invitation was extended to the identified judges. Six judges and one referee accepted the invitation to participate in the study and were interviewed. One judge who was originally invited to participate was not able to do so. Consequently, another judge from the same borough was invited to participate and was interviewed.

(b) Representatives of private child welfare agencies that provide congregate care ("agency representatives"). A list of agencies was jointly developed by the Research Partners based on their knowledge of agencies that provide significant levels of congregate care placements and services under contract with ACS. The list of agencies was further refined in collaboration with ACS. ACS mailed to each identified agency a letter explaining the study and encouraging the agency's participation in the study. Children's Rights made telephone contact with all identified agencies to request an interview. All of the 14 agencies who were invited agreed to participate in the study and were interviewed.

(c) Law guardians. Two of the Research Partners – LFC and JRD – provide law guardians as legal representatives for children and youth in foster care. JRD represents between 90% and 95% of the children and youth who are court-placed into the New York City foster care system, and LFC represents between 80% and 90% of the children and youth voluntarily placed into the City's foster care system. Representatives of LFC and JRD on the research team developed a list of law guardians in each of their organizations who, in their judgment, had a level of experience and expertise that would allow them to comment on the issues on which the study

1Appendix A provides a list of the agencies and organizations from which representatives were interviewed and the boroughs of the judges and referee who were interviewed.
focused. Children’s Rights contacted the law guardians by telephone and invited them to participate in the study. Of the 12 law guardians that JRD and LFC identified as possible study participants, 10 agreed to participate and were interviewed.

(d) Social workers. LFC and JRD also provide social work services to the children and youth whom their organizations legally represent. Representatives of these organizations provided a list of social workers who, in their judgment, had a level of experience and expertise that would allow them to comment on the issues on which the study focused. Children’s Rights contacted the social workers by telephone and invited them to participate in the study. Of the 13 social workers that JRD and LFC identified as possible participants, 11 agreed to participate and were interviewed.

(e) Representatives of advocacy and other relevant organizations (“organizational representatives”). The Research Partners jointly developed a list of advocacy and other relevant organizations in New York City with expertise on issues that affect youth in foster care. This list of organizations was subsequently refined in collaboration with ACS. Children’s Rights contacted the identified organizations and invited them to participate in the study. All 14 invited organizations agreed to participate and were interviewed.

(f) Young adults. In addition to these professional stakeholder groups, interviews were conducted with young adults ages 18 to 25 who had been in foster care and had been placed in group or residential settings during their stays in care. Originally, the study’s methodology included interviews with youth under the age of 18 who were still in care. The New York State OCFS, in its review of the study, however, mandated that the study incorporate certain procedures which, in some cases, created undue time and logistical constraints (such as the requirement that the consent of both the youth’s parents and ACS be obtained in all cases in which parental rights had not been terminated) and which, in other cases, created ethical dilemmas for members of the Research Partners (such as the requirement that any information related to maltreatment be reported to both ACS and the State Child Abuse Hotline even in cases when an older teen requested that the information not be reported). As a result of these requirements, the Research Partners revised the methodology to involve interviews with young adults discharged from care who could independently consent to participate in the study and who were not subject to mandatory child maltreatment reporting requirements.

Young adults were identified and invited to participate in the study through three approaches: (1) LFC and JRD identified former clients who had been discharged from care and with whom they maintained a level of ongoing contact; (2) Children’s Rights conducted outreach efforts to youth-serving organizations for assistance in identifying youth who met the interview criteria (they were between the ages of 18 and 25, formerly were in foster care, and had had a group or residential placement while in care) and would be interested in being interviewed (these organizations included The Lantern Group, Covenant House, The Door, and Voices for Youth); and (3) Children’s Rights inquired of young adults who were interviewed whether they were aware of other eligible young people who might be interested in participating in the study. The majority of youth who were interviewed (86%) were identified through outreach efforts to youth-serving organizations. Youths were paid a $25 stipend for participation in interviews and reimbursed subway fare when applicable. Most interviews (80%) took place at the offices of Children’s Rights.
Table 1 provides the number of participants who were interviewed from each stakeholder group.

**Table 1: Study Participants**

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<tr>
<th>Stakeholder Group</th>
<th>Number of Individuals Interviewed</th>
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<td>Judges</td>
<td>7</td>
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<tr>
<td>Representatives of Private Child Welfare Agencies</td>
<td>14</td>
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<tr>
<td>Social Workers</td>
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<tr>
<td>Law Guardians</td>
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</tr>
<tr>
<td>Representatives of Advocacy Organizations</td>
<td>14</td>
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<tr>
<td>Young Adults</td>
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*Interview Guides.* All interviews were conducted using instruments developed for each stakeholder group. Protocols were developed in consultation with the study's consultants, Dr. Deborah Padgett, Ph.D., MPH, Professor of Social Work, New York University, and Joan Morse, Director, Independent Living Resource Center, Hunter College School of Social Work, New York, NY. All protocols were pilot-tested and finalized based on the results of the pilot tests.

*Recruitment, Training and Support of the Interviewers.* Interviewers were recruited from three sources. First, research assistants were recruited via notices posted at leading graduate schools in New York City and on web-based not-for-profit job listings. Children's Rights selected graduate students as research assistants based on prior research experience, primarily in the area of qualitative research, and experience in the field of child and youth services. Second, policy and legal staff members at Children's Rights were identified as qualified interviewers. Finally, attorneys and social workers affiliated with JRD and LFC were included because of their interest in interviewing the judge stakeholder group.

All interviewers received in-depth briefings on the study and its objectives. Dr. Padgett and Ms. Morse provided a series of training sessions to the interviewers on qualitative research techniques, confidentiality, interviewing skills, and effective and appropriate utilization of the protocols to ensure validity and consistency. Children's Rights conducted ongoing training and debriefings throughout the interview process to ensure interview quality and to address ethical and other issues that arose during the interviews.

*Protection of Study Participants.* The study's methodology was overseen by a National Advisory Board of leading child welfare experts that was convened at the outset of the study to guide all aspects of the design and implementation. Three members of the National Advisory Board – Dr. Rosemary Avery, Dr. Gary Mallon, and Dr. Tony Maluccio – served as the study's Institutional Review Board (IRB), reviewing and approving the study's protocols and processes and ensuring that all considerations related to protection of human subjects were appropriately addressed. In addition, the study's protocols and processes were reviewed by the ACS Institutional Review Board and received that body's approval.

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2 The members of the study’s National Advisory Board are listed in Appendix B.
Informed consent was obtained verbally from respondents in the professional stakeholder groups. Young people were provided with informed consent forms that interviewers explained verbally and which the young adults were requested to sign. All interviews were conducted under conditions of strict confidentiality. The majority of interviews (94%) were audiotaped. Notes were taken during interviews as an alternative to audiotaping when respondents stated that they did not wish to be audiotaped. All data (audiotapes, transcripts, and interviewer notes) were labeled numerically and referenced only by identifying code numbers. Only the principal investigator and project manager had access to identifying information that was retained in locked files. All data analyses were conducted using identifying code numbers.

Data Transcription. Audiotapes were transcribed using a 2-reviewer sequential method. Two research assistants or professional staff members at Children's Rights who had not conducted the interview were assigned to review and transcribe each interview. The first stage of the review, by assigned Reviewer #1, involved transcribing from the audiotape all interview content, organized by each of the substantive domains. The second stage involved Reviewer #2's review of the audiotape, verifying and/or refining the transcript of Reviewer #1. This process was implemented after testing an alternative (but extremely time-consuming) approach that consisted of having two wholly independent transcripts prepared of each interview. This two-stage process revealed extremely high consistency between reviewers. For those interviews in which notes were taken and the interview was not audiotaped, the notes were reviewed and organized by substantive domain.

Data Analysis. Because the researchers entered the data analysis phase using the pre-defined domains as a classification scheme, a “template” approach to organizing and analyzing qualitative data was followed (Crabtree & Miller, 1999, p. 134). First, transcripts were read (and re-read) to retrieve all comments of each stakeholder group according to the substantive domains (placements, services, safety, permanency, transitioning from care, youth involvement, and recommendations). This step resulted in lengthy summaries that were shared with the Research Partners and the interviewers to check for thoroughness and accuracy. Next, the principal investigator organized and synthesized the comments and observations across the stakeholder groups for each domain. This step revealed key themes and issues that cut across the stakeholder groups for each domain. This step revealed key themes and issues that cut across the stakeholder groups for each substantive area.

The principal investigator then organized the themes and issues into separate sets of preliminary findings for professional stakeholders and for young adults. Each set of findings contained overarching themes illustrated by verbatim quotes from the interviews. Representatives of the three Research Partners reviewed the findings from the professional stakeholder interviews and offered suggestions to enhance their structure and organization. To help corroborate the findings as grounded in the data, three research assistants who had been closely involved with the data (through transcription and assisting in the analyses) reviewed the findings and associated verbatim excerpts. As an additional check on accuracy and balance in how the findings were organized and presented, results from the professional stakeholder interviews were reviewed with two of the interviewees – an agency representative and a social worker. The resulting syntheses of the findings for the professional stakeholders and the young adult stakeholders are presented in a later section of this report.
2. Focus Groups with Young Adults
In addition to the individual interviews with young adults, two focus groups were conducted with young adults ages 18 to 25 who formerly had been in foster care and had been placed in congregate care settings. Both groups were convened at Schafer Hall, an apartment residence for young adults who were formerly in foster care that is operated by The Lantern Group. Ten young adults participated in the focus groups. The focus groups, facilitated by Joan Morse, used a story boarding technique in which the young adults were asked to answer three questions:

- What worked well for you in congregate care?
- What did not work well for you in congregate care?
- What recommendations would you make to improve the foster care system for teens in care?

The young adults were asked to write on squares of paper one or more items that responded to each question which were posed in sequence with discussion after each question. The facilitator (Ms. Morse) collected the paper squares from each participant and asked participants to talk more about their thoughts. She then placed the squares on the “story board” (a sheet on which the squares would “stick”) and organized the squares into groups of related issues. The same process was used for each of the questions. The data were collected from the focus groups in two ways: (1) Ms. Morse developed a written grid of the “story board” responses that she provided to the principal investigator; and (2) a member of Children’s Rights’ staff attended each focus group as a “scribe” to take notes on the discussion and capture, to the extent possible, the young adults’ direct quotes.

Information Gathering From the Administration for Children’s Services (ACS)
In addition to the research methods that the study employed, information was obtained from ACS in order to create, to the extent possible, a picture of the agency’s activities and efforts on behalf of youth in congregate care. The approach involved constructing a “bottom up” picture of the agency’s efforts through group and individual interviews with representatives who had direct involvement in ACS operations and program activities. In addition, information was obtained from representatives at higher administrative levels in the organization. This approach provided ACS with full latitude to construct its own presentation and present its own institutional perspective on the issues on which the study focused.

The Research Partners developed a list of ACS program and administrative areas that appeared relevant to the study and requested that ACS representatives from those areas be invited to participate in group interviews. ACS worked closely with the Research Partners to further develop and refine the list of group interview participants. With the assistance of the ACS liaisons for the study (Jennifer Jones Austin and Anne Williams-Isom), four group interviews were held (a total of 20 ACS representatives participated). In the group interviews, each participant was asked three key questions:

- What are the primary roles and responsibilities of your program or administrative area as they relate to youth in care?
• What are the key achievements on behalf of youth in care that your program or administrative area has accomplished?
• What are the key challenges that your area confronts in improving placements, services, and/or outcomes for youth in foster care, in general, and youth in congregate care, in particular?

Children’s Rights prepared summaries of each of the focus groups that the principal investigator then analyzed to determine the areas in which additional information was needed. Based on that analysis, the principal investigator requested follow-up individual interviews with nine ACS representatives, which were arranged by the ACS liaisons. Most of the individuals who were interviewed individually had participated in the initial group interviews. These interviews were conducted by the principal investigator and/or by professional staff members of Children’s Rights. Representatives of LFC and JRD also attended these interviews. Respondents were asked questions to clarify issues discussed in the group interviews, to update information, and to share their views regarding some of the issues that had arisen in the interviews with the professional stakeholder groups (which had been completed at the time of these interviews). These interviews were not audiotaped. Data were recorded through note taking, with summaries of the interviews prepared and reviewed by representatives of the Research Partners. After this review and the completion of these summaries, the principal investigator organized all data gathered through the group and individual interviews with ACS representatives into the substantive domains on which the study focused. This synthesis was provided to ACS for review and comment to ensure the accuracy and completeness of the data. ACS representatives edited the summary and provided the Research Partners with an institutionally approved summary of the information that had been sought. This information is included in the section, The Systemic and Budget Environment.3

Addressing Potential Bias
Qualitative methods have a number of different approaches to addressing methodological bias and therefore do not rely upon the "traditional" quantitative standards of reliability and validity (Patton, 2002). Additionally, qualitative evaluation (like quantitative evaluation) must address fairness and respect for stakeholders and conservation of scarce resources, e.g., staff time and study’s budget. Thus, utilization-focused evaluation involves the broad-based involvement of stakeholders throughout the inquiry while at the same time adopting targeted, time-conserving protocols for minimizing bias.

Among the various “strategies for rigor” available to qualitative investigators (Padgett, 1998), the researchers used several strategies to enhance the credibility and trustworthiness of this study. As mentioned earlier, nationally-recognized research expertise was available from members of the Advisory Board as well as the research consultant (Dr. Deborah Padgett). Thus, the protocols for interviewer training, study design, sampling, data collection and data analysis followed established guidelines for decision-making within the flexible approach of qualitative methods. Second, preliminary findings were shared with the Research Partners, corroborated by the research assistants, and “member checked” with two interviewees. By interviewing a broad, diverse group of stakeholders, the key study findings were “triangulated,” that is, corroborated through multiple reference points among the stakeholder groups. Finally, the principal investigator kept lengthy memos and documentation of key study decisions so that an “audit trail” could
be developed for external review of the study's methods, if necessary.

**Strengths and Limitations of the Study**

As stated above, this study benefited from the use of several strategies for rigor which enhanced its credibility. Of course, no study (qualitative or quantitative) is entirely free of bias, and the researchers admit that the findings and recommendations might be unintentionally influenced by the interests of those involved. Specifically, the researchers acknowledge potential limitations to the study including the reliance upon youths over age 18 (rather than those currently in congregate care), the relatively small samples of interviewees and lack of follow-up interviews, and the possible lack of generalizability of the findings beyond the New York City area.

The decision to interview youth over age 18 already discharged from care carried with it both benefits and limitations. As benefits, youth between 18 and 25 years old brought maturity and perspective on their foster care experiences. As has been found in other studies that have interviewed youth retrospectively on their experiences in foster care (see Courtney, Piliavin, Grogan-Kaylor, & Nesmith, 2001; Taussig, 2002), these young adults were able to present a more nuanced view of the positives and negatives of their foster care experiences, having had the benefit of time, experience in the “real world,” and greater maturity.

Nonetheless, the ideal population to be interviewed in this study would have been youth currently in congregate care as their experiences would reflect the current system of placements and services, as opposed to a possibly different system in the past. As noted earlier, the original study methodology involved interviews with youth currently in congregate care. Although the protocols for this aspect of the study were approved by both the study's and ACS' Institutional Review Boards, the State-level review board through the Office of Children and Family Services mandated several modifications of the protocols. Some of these additional mandates – particularly those regarding child maltreatment reporting and the consent of youth’s parents in all cases other than those in which parental rights had been terminated – proved insurmountable. These mandates presented ethical conflicts for the partnering organizations that provide legal representation to youth in care. Consequently, the methodology was revised to interview young people discharged from care and over age 18 in order to include, prominently, the voices of youth in the report.

Decisions about sample size and one-time-only interviews were driven by constraints of time and staff resources as well as a desire to minimize the burden on interviewees (and, as such, are common in qualitative evaluation). Nevertheless, careful purposive sampling strategies were used to enhance both the quantity and quality of information received. Future qualitative studies involving ethnographic research and in-depth interviews with diverse populations of youths, families, and service providers would provide an “ideal” scenario for learning about the complicated, ever-changing landscape of congregate care.

The researchers address the issue of generalizability by first offering two caveats: (1) deep, local understanding is a strength of qualitative methods (as opposed to the broad generalizability expected of quantitative findings); and (2) evaluation findings and recommendations are usually intended solely for “local” use and, thus, their utility elsewhere is not at issue. However, “knowledge-generating” (generalizable) qualitative evaluations have gained favor in recent years (Patton, 2002, p. 220), and the researchers were mindful of this issue when carrying out the study.
The researchers acknowledge that New York City is extraordinary in the “scope of the problem” (i.e., the number of children and youth in care), in the amount of public and private monies spent on congregate care, and in the number of bureaucratic entities involved in the city’s vast system of care for children and youth. Yet, to a large extent, the situation in New York City is often considered a “bellwether” or “cautionary tale” for other large cities’ social service systems. In this context, the researchers contend that many of the study’s findings are useful for service providers elsewhere.

In conclusion, the study’s methods constituted an empirical approach for going beneath and beyond the stereotypes, assumptions, and received wisdom about the experiences of youth in foster and congregate care. Although in some cases it confirmed previous understanding of these issues, in other cases, it brought unexpected light to the realities of teens’ experiences. As such, the qualitative approach used in this study involved the systematic collection and analysis of data rather than relying on anecdote and common sense.

THE RESEARCH LITERATURE REVIEW

The research literature primarily addresses the general experiences of and outcomes for youth in foster care, and to a far more limited extent, it addresses issues that specifically affect youth in congregate care. This review of the current knowledge base describes what is known about the issues affecting youth in foster care in general, recognizing that this information provides an important context for the issues on which this study focused. Whenever possible, however, it discusses what is known about the experiences of youth in congregate care.

This section begins with an overview of some of the key demographic characteristics of children and youth in foster care. It then describes the current knowledge base in the six substantive domains of this study:

• The types and the quality of placements for youth in foster care;
• The services that youth in care need and receive;
• Safety issues that impact youth in care;
• Permanency planning and permanency outcomes for youth in care;
• The involvement of youth in foster care in decision-making on issues that directly affect them; and
• Youth’s transitions from foster care.

DEMOGRAPHIC CHARACTERISTICS OF YOUTH IN FOSTER CARE

Three demographic characteristics of children and youth in foster care provide an important context for understanding the experiences of youth in congregate care:

• The significant number of children in foster care who are 12 years old and older;
• The disproportionate representation of children and youth of color in foster care; and
• The long stays in foster care that many children and youth experience.
The number of children and youth in foster care
Nationally, there were 542,000 children in foster care in 2001 (U.S. Department of Health and Human Services, 2003a). The mean age of the children was 10.1 years, and the median age was 10.6 years. Almost half (49%) of all children in foster care were age 11 and older (30% were ages 11 through 15; 17% were ages 16 through 18; and 2% were ages 19 or older) (U.S. Department of Health and Human Services, 2003a).

In New York City, about one-half of the children in foster care are adolescents (age 12 and over). The number of adolescents entering foster care each year has declined since 1999. In 1999, 3,550 adolescents were admitted to foster care; in 2000, 3,251 adolescents were admitted to foster care; and in 2001, the number declined to 3,142 (New York City Administration for Children’s Services, 2003a). Table 2 provides the most recent (2002) data on all adolescents in foster care in New York City by age range.

Table 2: Ages of Adolescents in New York City – 2002 (N=12,940)

<table>
<thead>
<tr>
<th>Age Range</th>
<th>Percentage of Adolescents in Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>12-14</td>
<td>34.1%</td>
</tr>
<tr>
<td>15-17</td>
<td>42.8%</td>
</tr>
<tr>
<td>18 and older</td>
<td>23.1%</td>
</tr>
</tbody>
</table>

(New York City Administration for Children’s Services, 2003a)

Disproportionate representation of children and youth of color
Nationally, the majority of children and youth in foster care are from communities of color. In 2001, 38% of the children and youth in care were black, 17% were Latino, 2% were Native Americans, and 1% was Asian/Pacific Islander (U.S. Department of Health and Human Services, 2003a). African American children, in particular, continue to be over-represented in the foster care system when compared to their representation in the U.S. child population (in 2000, for example, they constituted only 14.7% of the U.S. child population) (O’Hare, 2001).

In New York City, children and youth of color comprise a large percentage of the population in foster care. As Table 3 shows, black children and youth are disproportionately represented in the City’s foster care system.

Table 3: Racial and Ethnic Composition of Children and Youth in Foster Care in New York City – 2001

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Black</td>
<td>53.3%</td>
<td>26.6%</td>
</tr>
<tr>
<td>Latino</td>
<td>21.5%</td>
<td>27%</td>
</tr>
<tr>
<td>White</td>
<td>24.4%</td>
<td>44.7%</td>
</tr>
<tr>
<td>Unknown</td>
<td>0.8%</td>
<td>--</td>
</tr>
</tbody>
</table>

Length of stay in foster care

National data indicate that in 2001, children and youth in foster care were in care for a mean of 33 months and a median of 19 months (U.S. Department of Health and Human Services, 2003a). Close to one-third of children and youth nationwide (32%) had been in care for 3 years or more (U.S. Department of Health and Human Services, 2003a). National data do not indicate length of time in care by age group.

New York City data, however, indicate that a large percentage of older children and youth in care have spent more than 3 years in foster care (see Table 4).

Table 4: Length of Time in Care for Youth in New York City (As of December 31, 2001)

<table>
<thead>
<tr>
<th>Age Category</th>
<th>Percentage of Youth in Care for More than Three Years</th>
<th>Number of Youth in Care for More than Three Years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Youth ages 10-13</td>
<td>61.9%</td>
<td>5,660</td>
</tr>
<tr>
<td>Youth ages 14-17</td>
<td>51.7%</td>
<td>6,033</td>
</tr>
<tr>
<td>Youth ages 18 and older</td>
<td>80.4%</td>
<td>2,512</td>
</tr>
</tbody>
</table>

New York City data suggest that the length of time that adolescents remain in care may be decreasing, particularly for youth who recently entered care. ACS (2003a) reported that of the 3,142 youth who entered care in 2001, one-half exited care within one year (28.8% within 3 months, 8.8% between 4 and 6 months, and 13.3% between 7 and 12 months). Data, however, do not indicate whether the proportion of youth in care for more than three years has declined.

PLACEMENTS FOR YOUTH IN FOSTER CARE

A number of issues related to the placements of youth in foster care have been addressed in the research literature. The key issues that are relevant to this study are:

- The types of placements that are utilized for children and youth in foster care;
- The number of placements that children and youth experience while they are in care;
- Placement issues for special populations, particularly teen mothers and youth who are gay, lesbian, bisexual, transgender, or questioning (GLBTQ); and
- Youth’s perceptions of the appropriateness and quality of their placements in foster care.

Types of placements for youth

Nationally, data indicate that children and youth are placed in a variety of settings while in foster care. In 2001, almost half of the children in foster care were placed in homes with non-relatives (48%), and close to one quarter (24%) were placed with relatives (U.S. Department of Health and Human Services, 2003a). Close to one-fifth of all children and youth in care were in congregate care arrangements: 8% were in group homes; 10% were in institutions; and 1% were in supervised independent living programs (U.S. Department of Health and Human Services, 2003a). National data do not indicate placement type by the age of children and youth.
Data in New York City, however, provide a better understanding of placements for teens. As Table 5 shows, one-third of all youth ages 11 and older in foster care in New York City in 2001 were placed in some type of congregate care setting.

### Table 5: Placement Settings for Youth Ages 11 and Older in Care in New York City (December 31, 2001) (n=12,804)

<table>
<thead>
<tr>
<th>Type of Placement</th>
<th>Percentage of Youth in Setting</th>
<th>Number of Youth in Setting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Congregate Care Settings</td>
<td>33%</td>
<td>4,204</td>
</tr>
<tr>
<td>Foster Boarding Homes</td>
<td>40%</td>
<td>5,063</td>
</tr>
<tr>
<td>Approved Relative Homes</td>
<td>26%</td>
<td>3,305</td>
</tr>
<tr>
<td>Other Placements</td>
<td>2%</td>
<td>232</td>
</tr>
</tbody>
</table>

(New York State Office of Children and Family Services, 2002)

More recent data indicate that, as of December 2002, a total of 4,281 children and youth of all ages were placed in congregate care – the great majority with contract agencies (96%) and only a small percentage in ACS direct care congregate settings (4%) (New York City Administration for Children's Services Office of Management Development and Research, 2003). Data from 2001 indicate that of the youth in congregate care placements in New York City, more than half (54%) were placed out-of-county and a small percentage (3%) were placed out-of-state (New York State Office of Children and Family Services, 2001).

ACS data (2003a) provide information on the extent to which different types of congregate care are used for different age groups of youth. Table 6 provides a summary of the percentages of youth placed in different types of congregate care settings with comparison information on the percentages of youth placed with kin and with unrelated foster parents.

### Table 6: Family-Based and Congregate Care Placements for Adolescents by Age Group (March, 2003)

<table>
<thead>
<tr>
<th>Type of Placement</th>
<th>Youth ages 12-13</th>
<th>Youth ages 14-15</th>
<th>Youth ages 16-17</th>
<th>Youth ages 18+</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kinship</td>
<td>29.8%</td>
<td>24.1%</td>
<td>18.2%</td>
<td>21.2%</td>
<td>23.1%</td>
</tr>
<tr>
<td>Unrelated foster family care</td>
<td>51%</td>
<td>34.1%</td>
<td>30.4%</td>
<td>32.7%</td>
<td>36.6%</td>
</tr>
<tr>
<td>Congregate care total</td>
<td>17.7%</td>
<td>39.6%</td>
<td>48.8%</td>
<td>41.3%</td>
<td>37.5%</td>
</tr>
<tr>
<td>Group home or group residence</td>
<td>2.6%</td>
<td>10%</td>
<td>18.3%</td>
<td>20.6%</td>
<td>13%</td>
</tr>
<tr>
<td>Institution</td>
<td>9.8%</td>
<td>21.4%</td>
<td>23.7%</td>
<td>8.5%</td>
<td>16.5%</td>
</tr>
<tr>
<td>Other forms of congregate care</td>
<td>5.3%</td>
<td>8.1%</td>
<td>6.9%</td>
<td>12.1%</td>
<td>8.1%</td>
</tr>
</tbody>
</table>

(New York City Administration for Children’s Services, 2003a).
These data, although showing the official placements of the majority of youth in foster care do not necessarily reflect the actual placement status of all youth in care. Some proportion of youth in foster care, for example, run away and are placed on AWOL status and have no placement at all. One study (Courtney, Piliavin, Grogan-Kaylor, & Nesmith, 2001) found that 37% of youth had run away from their out-of-home placements while in care, and another study found that of the youth who had run away, two-thirds had run away more than once (Flowers, 2001). A study by the Vera Institute (2001) examined the experiences of youth between the ages of 11 and 15 who entered New York City foster care on PINS petitions, voluntary agreements, and as a result of child abuse and neglect. It found significant rates of at least one AWOL during youth's stays in care. The highest AWOL rates were among youth placed on voluntary agreements (49%) and youth placed on Person in Need of Supervision (PINS) petitions (48%). Close to one-third (29%) of the youth who entered care because of abuse and neglect, however, had at least one AWOL. The study also found that 18% of all youth were eventually considered “discharged” by virtue of their prolonged AWOL status, the second highest discharge destination (after return to a parent or relative).

**Number of placements while in care**

One issue related to the placements of youth in foster care is the number of placements they experience while in care (Wilson, 2000). One of the national outcomes that the U.S. Department of Health and Human Services has set and now monitors through the federal Child and Family Service Reviews is reduction in the number of placements for children and youth in care (U.S. Department of Health and Human Services, 2003b). The performance measure on this outcome is that 86.7% of children in foster care for less than 12 months experience no more than two placements (U.S. Department of Health and Human Services, 2003b). In the most recent annual report on states' performance on this outcome (for 2000), only 17 states met the measure for this outcome, and New York State was among them (U.S. Department of Health and Human Services, 2003b).

Data provided by ACS (2001) reflect relatively high levels of placement stability over a 12-month period for children and youth who entered foster care in 1999 (though not at the level of the national standard): 65% of these children and youth remained in their initial placements, 22% experienced one additional placement, and 13% experienced two or more additional placements. More recent data on the number of placements for children and youth in New York City are not available but might be expected to show improved percentages given the high level of New York State's performance on this outcome.

Research suggests that the longer children remain in care, the more likely they are to have multiple placements. New York State data, for example, show that that in 2000, only 58.5% of children and youth in care between three and four years had two or fewer placements, and only 44% of children and youth in care for four years or more had two or fewer placements (U.S. Department of Health and Human Services, 2003b). In the commentary, the federal reviewers expressed concerns about placement stability in a number of the reviewed cases, noting a lack of appropriate matching of children and youth with foster parents and incomplete assessments of children's placement needs (U.S. Department of Health and Human Services, 2003b). Data reflecting the number of placements for youth in care for longer periods of time (particularly youth in care for more than three years) would provide a clearer picture of placement stability in New York City but are not currently available. Given the implications of multiple placements on both youth well-being and success in achieving permanency (Brady & Caraway, 2002; Gallant, 2000), this issue is one in which greater attention in the research literature is needed.
**Placement issues for special populations**
Two populations have received some attention in the literature with regard to placement needs: teen mothers and their children and GLBTQ youth.

**Placements for teen mothers and their children**
The issue of placements for teen mothers and their children has received some attention in New York City. The Youth Advocacy Center (YAC) (1995) focused on this issue in a study that involved interviews, focus groups, and surveys with teen mothers and interviews with social workers and city officials. The study found that in most cases, teens who became pregnant while in foster care were placed in maternity residences until they gave birth, followed by placement in a mother/child group home. The study found that because mothers were not placed in mother/child homes until after they had given birth, pregnant teens did not know where they would live until after their children were born. In some cases, the placement process took weeks, requiring mothers to leave their infants in hospitals as they awaited mother/child placements. In certain cases, teen mothers were shuttled between temporary foster homes. The study also found that once a mother/child placement was identified, it was not necessarily permanent or appropriate (Youth Advocacy Center, 1995). This issue has not been methodically studied since the 1995 YAC report.

**Placements for GLBTQ youth**
GLBTQ youth also face placement-related issues. One issue is the extent to which appropriate placements are available for them. Mallon (1992, 1997) has documented the negative experiences of GLBTQ youth in group care placements, particularly with regard to the attitudes of other youth and some staff members toward these youth, and with DeCrescenzo (2000), has highlighted the need to develop supportive placements for GLBTQ youth. The extent to which placement resources will accept GLBTQ youth is another critical placement issue. One study in New York City found that some group and foster homes refused to accept GLBTQ youth and, as a result, in some cases these youth had to be placed in psychiatric facilities (cited in Sullivan, Sommer, & Moff, 2001). Although the New York State OCFS has not mandated GLBTQ policies and programs for all child welfare agencies statewide, ACS has issued a policy bulletin on its non-discrimination policy on sexual orientation (Sullivan, Sommer, & Moff, 2001). The impact of this policy has not been fully assessed.

**Youth perceptions of their placements**
There has been only limited research that focuses on youth's perceptions of their placements while in foster care. To the extent that research is available, it suggests that children and youth have varying views of their experiences in group care. The National Survey of Child and Adolescent Well Being (NSCAW) (2002) found that children and youth living in out-of-home care for one year were generally satisfied with their living arrangements and schools, but children and youth residing in group care were less satisfied with certain aspects of their experiences. Children in group care were almost 4 times as likely as those in non-relative foster homes and were 10 times as likely as those in kinship care to report that they did not like the people with whom they were living.

In another study (Courtney, Piliavin, Grogan-Kaylor, & Nesmith, 2001), researchers asked youth who had aged out of foster care about their foster care placements. About half of the youth interviewed in this study had spent time in congregate care, and most believed that it was an appropriate placement for them.
Researchers also asked youth before they left foster care, “Were there any services that would have allowed you to remain in a less intensive setting, like a foster home, rather than a group care setting, or institutional setting?” The majority (82%) did not believe that additional services would have been helpful. Only 12% (8 youth) felt that services could have helped, while 6% (4 youth) did not know or did not answer.

The researchers also interviewed the same young people after they had exited foster care (12 to 18 months following their discharges). At that time, the majority of young adults said they had positive relationships with their out-of-home caregivers, and 73% reported being generally satisfied with their experiences in out-of-home care. Seventy-five percent said they felt “somewhat close” or “close” to the adults who provided them with care, a finding echoed in a study by the New York State Office of the Family and Children's Ombudsman (2001) in which youth reported that they had positive feelings about their foster families when they were treated like everyone else in the family and allowed to visit their birth families regularly. About half of the young adults, however, said they felt that being in out-of-home care was not like being in their own families and wished that they knew more about their family backgrounds.

The study by Courtney and colleagues (2001) found that a number of young adults had negative views of the child welfare agency responsible for their care. Close to one-fifth (17%) felt that the agency did not have their best interests in mind, and more than one third of the young adults thought that the agency had too much control over family visiting. One third of the respondents reported that they had been mistreated while in out-of-home care (Courtney, Piliavin, Grogan-Kaylor, & Nesmith, 2001).

In another study, Casey Family Programs (2003) interviewed alumni of the Casey foster care program and asked them to describe the interventions while they were in foster care that made a difference in their success or non-success. The young adults reported that the following factors were especially important when they were teens in foster care: discipline and structure, even if they did not like these restrictions at the time; having someone show them the value of school; sensitivity to mental health issues; placement with families who “matched,” that is, families who recognized the youth as an individual, whom they could trust and who valued the young person's own religion, and ethnic and cultural identity; caregivers’ patience; having their own money; and not feeling like a commodity (that is, not feeling that they were merely a conduit to money for their caregivers).

**SERVICES FOR YOUTH IN FOSTER CARE**

Research indicates that youth in foster care have multiple service needs – particularly in the areas of health and education. Studies do not typically distinguish between the service needs of youth in congregate care and youth placed in family-based foster care, but the findings provide a useful context for understanding the service needs of youth in care in general.

**Health services**

Numerous studies have documented high rates of acute, chronic, and disabling health conditions, both physical and emotional, among youth in foster care (National Foster Care Awareness Project, 2000; Child Trends, 2002). Studies also have identified the impact of risk taking behaviors on adolescent health (National Survey of Child and Adolescent Well Being, 2002) and the specific health needs of GLBTQ youth (Mallon, 2001). Research also has indicated that despite high levels of health needs, there are numerous barriers to meeting those needs for children and youth in foster care.
Physical health needs
Researchers have found that 30% to 40% of youth in the child welfare system are affected by chronic medical problems (Simms, Dubowitz, & Szilagyi, 2000), including one study of children and youth in foster care in New York City (New York State Office of Children and Family Services, 2000). Few studies specifically have focused on the general medical problems of children and youth in congregate care. One study, however, suggested that youth in residential settings experience acute medical problems (such as allergies and ingestion of toxic substances), accidents, chronic medical problems (such as seizure disorders and asthma), substance abuse, and somatized emotional reactions (such as tics and enuresis) (Powers, 1989).

Although studies of the specific physical health needs of youth in foster care are limited, research suggests that this population faces reproductive health issues and health issues related to sexual activity (Mayden, 1996). One study conducted in Vermont, for example, found that among youth in foster care who were 15 years and older, 86% were sexually active, but only 38% used contraception regularly and only slightly more than one-third (38%) believed they were at risk of HIV (Brownyn, 1996).

Mental health service needs
Emotional and mental health problems among children and youth in foster care have been well-documented, with studies suggesting that between 29% to 80% of the foster care population have mental health problems (Heflinger & Simpkins, 2002). The Child Welfare League of America (2002), for example, has estimated that 60% of children and youth in foster care have moderate to severe mental health problems.

New York City data indicate that in 2000, more than half (57%) of the children and youth in care had mental health problems (New York State Office of Children and Family Services, 2000). This finding is consistent with other studies that have documented the incidence of mental health problems among children and youth in foster care in other communities:

- A California study found that more than 80% of children in foster care in Oakland had developmental, emotional, or behavioral problems. Nearly 49% of the children had mental health disorders, and 53% had developmental problems (Halfon & Klee, 1991). Another study conducted in California found that 77% of teenagers in foster care were in need of a mental health referral (Klee & Halfon, 1987).
- One study of youths ages 12 through 17 in foster care in Minnesota found that almost half had a disability, and many were severely emotionally disturbed. The vast majority of the youth in this age group were in long-term foster care, and only half of the youth who were severely emotionally disturbed were receiving treatment (Wattenberg, 2002).
- A study of youth leaving foster care in Missouri found that 44% had been in inpatient psychiatric care at some point in time (McMillen & Tucker, 1999). Youth with these histories had the greatest number of placements of all children in care, averaging over seven placements each (McMillen & Tucker, 1999).

The research does not make clear the relationship between the mental health needs of youth and the type of placement. As a result, it cannot be definitively stated that youth in certain types of placements have more serious mental health problems. The NSCAW (2002) surveyed children and youth in out-of-home care and
found that children and youth in group care tended to be older than other children in care and when compared to children in family-based care, they more often scored in the borderline or clinical range for behavioral and cognitive problems. When age was controlled, however, the NSCAW found that children and youth in group care did not have higher clinical scores than children of the same age who experienced the same types of abuse and who resided in kinship care or with unrelated foster parents.

One study of 63 adolescents conducted in Washington State and Illinois, however, found that children placed by public child welfare agencies into group homes or institutions had more mental health service needs than children placed in less restrictive environments, such as family foster care (Altshuler & Poertner, 2002). In this study, youth in group homes or institutions reported lower self-esteem. Perceptions of self-esteem included whether the youth believed that they possessed good qualities, whether they liked themselves, whether they were satisfied with life, and whether they felt socially accepted. The study also found that adolescents in foster care generally reported higher levels of emotional discomfort than their peers who had never been in foster care (Altshuler & Poertner, 2002).

Because residential treatment programs are one component in the array of mental health services for children and youth, research has focused on the effectiveness of this form of treatment in improving children's and youth's mental health outcomes. The Surgeon General's Report on Children's Mental Health (U.S. Department of Health and Human Services, 2000) reviewed the results of key research on this issue and concluded that residential treatment has not been shown to provide substantial benefits for children and youth with mental health problems. The Surgeon General's Report cited several studies that found that residential treatment was no more effective than community-based care, but was, as one study documented, twice as expensive (Weinstein, 1984; Rubenstein, Aumentrout, Levin, & Herald, 1978). The Surgeon General's Report also suggested that residential treatment may adversely affect children and youth because of problem contagion from one child to another. It found that far more positive outcomes were associated with home- and community-based treatment (such as multi-system therapy, intensive case management, and treatment foster care) for youth with severe emotional and behavioral problems. Research, including that conducted by Henggeler, Schoenwald, Bordwin, Rowland, and Cunningham (1993), further suggests that even when youth are suicidal or prone to run away, short-term hospitalization and community-based services may be more effective than residential treatment.

Risk-taking behaviors and health

One issue regarding health services for youth, including youth in foster care, is the extent to which services address and minimize risk-taking behaviors. Although research is limited regarding the extent to which youth in foster care engage in risk-taking, studies suggest that youth in care may be prone to these behaviors. Studies suggest that youth in foster care may be at higher risk of engaging in high-risk sexual behaviors (including having a larger number of sexual partners), drug use, and other behaviors that place themselves at physical risk (Wertheimer, 2002). In one study that examined risk-taking behaviors among youth in group homes and institutional care, Altshuler and Poertner (2002) found high levels of risk-taking among youth. Youth in group and residential care settings were found to engage in risky behaviors on an individual level and also were driven to risk-taking by peer influences.
**Health needs of GBLTQ youth**

Although not all GLBTQ youth have special health care needs, research suggests that many of these youth have needs in the areas of reproductive health and parenting, trauma and sexual assault, eating disorders, substance abuse, depression/suicidal thoughts, and sexually transmitted diseases (Mallon, 2001). Additionally, research suggests that within this population, health needs may vary: lesbians, for example, may require gynecologists who can assist them with sexual health issues while gay males, who are statistically at the highest risk of STDs and eating disorders, may need relevant information on these issues (Mallon, 2001).

**Barriers to the provision of health care services to youth in care**

Research indicates that there are significant barriers to youth's receipt of both physical and mental health services. Studies repeatedly have documented that children and youth in foster care do not routinely receive needed physical health screening, diagnostic services, or treatment (Blatt & Simms, 1997; Howitz, Owens, & Simms, 2000; Simms, Freundlich, Battistelli, & Kaufman, 1999; Simms & Kelly, 1991). Those issues appear to be equally problematic in New York City. A Case Record Review conducted in 2000 by the New York State OCFS (2000) found that although medical and mental health screenings are required within 30 days of children's entry into foster care, they were not provided in one-third of the New York City cases that were reviewed. The cases were of children placed with foster families rather than in congregate care, but the results suggest problems in health care service delivery and information-sharing that are likely to affect all children and youth in care. In one-half of the cases, children and youth did not receive mandatory dental, eye, or tuberculin tests. Although one-third of the children suffered physical health problems and over half had mental health problems, nearly half (46%) of the children's foster parents were not apprised of children's health status. In addition, only about half (53%) of foster parents who needed services for children in their care were able to obtain those services. In only two-thirds of the cases in which children received services did caseworkers monitor the receipt and outcomes of those services. Of the cases reviewed, health-related documentation often was missing: less than 1% of the cases had a full medical history, only one-half indicated the child's immunization status, and less than half of the cases contained medical consents (New York State Office of Children and Family Services, 2000).

Similarly, despite the apparently high level of need for mental health services, it appears that youth in foster care, irrespective of placement type, often do not receive the mental health services that they need. Research has attempted to document the barriers to mental health services for youth in care. One recent study (Marsenich, 2002) found that a number of factors worked against youth's access to quality mental health services. In this study, mental health practitioners stated that:

- They often did not receive information on youth in care who were referred to them for treatment (including no information on the youth's developmental, educational, and behavioral background);
- They were not informed of changes in teens' placements; and
- When mental health staff and child welfare staff collaborated, their roles and responsibilities were not clear, including their respective responsibilities for ensuring that teens received needed special education services and other developmental, recreational, and health services.
The researchers also interviewed youth’s foster parents who reported:

- They often had to make repeated requests of child welfare caseworkers to obtain mental health referrals for children and youth in their care;
- In some cases, foster parents experienced such prolonged delays in obtaining referrals that placements disrupted because of youth’s unruly behavior before any mental health services were arranged; and
- They were not appropriately trained to handle adolescents’ difficult behaviors.

Research suggests that in many cases, children and youth enter congregate care (either group care or residential treatment) when family foster care disrupts because of emotional and behavioral problems of the children and youth (Barth, 2002). There are few third-party evaluations of the effectiveness of congregate care for children and youth in foster care who are placed in these settings for treatment purposes. As a result, it cannot be concluded that the therapeutic and clinical benefits of congregate care are greater than would be achieved with foster family care that is supported with a network of community-based mental health treatment and other services (Barth, 2002; U.S. Department of Health and Human Services, 2000).

The research literature suggests a strong association between the availability of health care insurance and youth’s access to mental health services. In New York City, the issues are particularly acute for children and youth placed in care with a private agency that contracts with ACS rather than placed in an ACS direct-care facility. Youth placed in an ACS direct-care facility receive services through Medicaid fee-for-service. Youth placed in congregate care with a private agency are served through Medicaid per diem arrangements, as required by New York law. The private agency’s per diem rate is based on its spending rate two years earlier as well as on the type of placement it provides, and the rate ranges from $2 to $33 per day per child (Citizens’ Committee for Children [CCC], 1998). Private agencies typically either seek other resources to fund health care services or limit treatment services to the per diem rate. In its study of these arrangements, the CCC characterized the per diem rate as “grossly inadequate” – as far too low to cover costs and as not taking into account the high level of youth’s mental health needs as a result of neglect, abuse, and separation from their families and communities. The CCC also noted that the per diem rate does not include the administrative costs of health care, such as conferences between doctors and caregivers or therapists’ preparation time for court appearances. In 2001, New York State began to allow residential treatment centers with on-site certified social workers to receive Medicaid reimbursement for these professionals’ services. The CCC, however, expressed concerns about the quality of these services, particularly the extent to which on-site certified social workers are specialized in treating youth in congregate care, and the extent to which agencies have the resources, infrastructure, and staff longevity to provide “state-of-the-art” treatment (Citizens’ Committee for Children, 1998).

**Educational services**

The research literature focuses on education as an area of concern for children and youth in foster care. These issues arise in connection with the academic performance of children and youth in care and in connection with special education services.
Academic performance

Studies consistently demonstrate that children and youth in foster care do not perform as well academically as do their peers who are not in care. The Washington State Institute for Public Policy (Burley & Halpern, 2001) compared the performance of youth in foster care on standardized tests with that of youth not in care and found that students in foster care scored, on average, 15 to 20 points below other students. The study found that at both the elementary and the secondary school levels, twice as many youth in foster care than non-foster youth had repeated a grade, changed schools during the year, or enrolled in a special education program. Other studies have found that between 26% and 40% of youth in care have repeated one or more grades (McMillen, Auslander, Elze, White, & Thompson, 2003; Edmund S. Muskie School of Public Service, 1999). Research indicates that significant percentages of children and youth in foster care – ranging from 30% to 96% - are below grade level in reading or math (Seyfried, Pecora, Downs, Levine, & Emerson, 2000; Haymes & Vidal de Haymes, 2000). A recent study of 262 youth in foster care in a midwestern U.S. county found other aspects of poor school performance – 58% of the youth had failed a class in the previous year – and significant levels of school disruption – 73% of the youth had been suspended once since the seventh grade and 16% had been expelled (McMillen, Auslander, Elze, White, & Thompson, 2003). Although the research is not extensive regarding the reasons that children and youth in foster care do not perform well academically, one recent study suggested that four factors affect their academic performance: aspiration for higher education, the placement setting (with youth in kinship care faring better academically), participation in extracurricular activities, and drug use (Shin, 2003).

Data indicate that the percentage of children in foster care in New York City who are over-age for their grade level ranges from 19% to 24%, depending on the year (New York City Administration for Children's Services, 2001). Students in higher grades are more likely to be over-age than students in lower grades. ACS' study of the academic performance of youth in foster care from 1995 through 1999 found that the percentage of over-age children and youth in foster care was 9% for those in the first grade but 42% for those in the tenth grade (New York City Administration for Children's Services, 2001).

Poor academic performance has been linked to school enrollment, a problem of concern in New York City. In 2001, ACS examined the New York City Board of Education's records and found that children in foster care often were not enrolled in school. Of the 16,211 children placed in foster care during the 1995 to 1999 time period, 11% were not enrolled in New York Board of Education schools at the time of their placements. Although some of these youth were being home-schooled, were enrolled in private or parochial schools, or had left the education system for institutions such as juvenile detention facilities, others were reported as having moved from New York City (although they obviously were living in New York City at the time of placement) or as having left school (although some of the children were 8 years old). For 44% of the children not enrolled in school, the Board of Education provided no explanation whatsoever for the child's failure to be enrolled in any school (New York City Administration for Children's Services, 2001).

One factor that has been identified as contributing to the educational problems of children and youth in foster care is poor school attendance (a factor obviously associated with enrollment). In 2001, data collected by ACS on children and youth in foster care indicated that the mean attendance for the children placed during 1995-1999 was 76% during the semester following their placements. Children and youth in
special education showed, on average, a decline in attendance between the periods pre-dating and following their placements in foster care. Children and youth in special education demonstrated lower attendance rates when compared both to children in regular elementary and middle schools and to children on probation for particularly poor performance. The data showed different trends for two groups of children: children who had above-median school attendance before placement showed a dramatic decline in school attendance after entering care, and children who had a below-median school attendance before placement showed a dramatic increase in attendance after entering care (New York City Administration for Children’s Services, 2001).

ACS (2001) also assessed data regarding the relationship between the length of time a child spent in foster care and changes in school attendance following placement. Data indicated the following:

- Children who left foster care quickly (that is, they were no longer in foster care at the start of the semester after placement) showed only a small decrease in attendance after they entered care;
- Children who were discharged from foster care in the middle of a semester had the poorest attendance; and
- Children who remained in care for at least one semester (five months or more) following placement showed an improvement in attendance.

Connected with school enrollment and attendance is the mobility of children and youth in foster care. The research literature suggests that the educational difficulties of children and youth in care are strongly associated with the fact that they move from placement to placement and must change schools (Yu, Day, & Williams, 2002). ACS (2001) collected school transfer data for children admitted into foster care for the first time between 1995 and 1999. Of these children, one-third had transfers (that is, placements into or out of special education or alternative high schools) for “non-educational” (that is, unexplained) reasons during the first 30 days of their placements. Most children who were transferred for unexplained reasons were between the ages of 5 and 13. Youth, however, comprised 26% of these transfers (New York City Administration for Children’s Services, 2001).

One issue of importance in connection with the academic performance of children and youth is the extent to which caseworkers monitor school attendance and academic performance. In a Case Record Review conducted in 2000, it was found that in 45% of the reviewed cases, there was no contact between the caseworker and the child’s school for at least one year (New York State Office of Children and Family Services, 2000).

Special education services
The research literature indicates that a significant proportion of children and youth in foster care have special education needs. The Child Welfare League of America (2002) has estimated that 20% of the children in foster care have developmental or learning disabilities, and studies have suggested that somewhat higher percentages of children and youth in foster care receive special education services – ranging from 30% to 41% (Goerge, Voorhis, Grant, Casey, & Robinson, 1992; Edmund S. Muskie School of Public Service & the National Resource Center for Youth Services, 1998; Yu, Day & Williams, 2002). In New York City, it is estimated that 20% of the children and youth in foster care need developmental services (Center
for an Urban Future, 2002). It is not clear to what extent children and youth in foster care with special education needs actually receive the services that they need.

An additional issue that is not addressed in the literature is the extent to which children and youth in foster care are inappropriately assessed as needing special education services. This aspect of educational services for children and youth in care is not well understood. Far more attention needs to be given to the special and regular educational service needs of children and youth in congregate care in particular, where educational services may be provided on-site (as in the case of residential treatment centers) or through the public education system (as in the case of group homes).

SAFETY IN FOSTER CARE

Although there is consensus that a safe and nurturing environment for all children and youth in foster care is essential, there is little in the research literature that examines the various aspects of safety for children or youth in care or the factors that undermine child safety in different placement settings. From a data perspective, the federal government has addressed and now requires reporting on one aspect of safety for children and youth in foster care: the percentage of children in foster care who are the subject of a substantiated or indicated report of child maltreatment by a foster parent or by the staff of a congregate care facility. A national standard of 0.57% has been set as the upper limit regarding the incidence of child maltreatment in foster care. New York State's rate of incidence of child abuse and/or neglect in foster care has been higher than the standard over the last three reporting years: it was 0.8% in 2000, an improvement over the 1.14% rate in 1999, but somewhat higher than the rate of 0.71% in 1998 (New York State Office of Children and Family Services, 2003; U.S. Department of Health and Human Services, 2003b). These percentages reflect serious issues regarding safety for children and youth in care, but do not allow an analysis of the rates of maltreatment in foster family homes versus congregate care settings. In addition, these data do not address such issues as peer-on-peer violence in congregate care facilities, threats to safety as a result of the physical status of the facility or the neighborhood in which the facility is located, nor the extent to which youth's personal belonging are safe in congregate care settings.

The research literature is somewhat fuller with regard to safety issues that affect GLBTQ youth. Studies suggest that these youth often are the target of discrimination, harassment, and violence from peers, foster parents, and group care facility staff (Sullivan, Sommer & Moff, 2001). Some researchers have found that safety concerns result in decisions by GLBTQ youth to run away from their group homes. One study, for example, found that gay, lesbian, bisexual, transgender and questioning youth are more prone to run away because of hostile living environments (cited in Sullivan, Sommer, & Moff, 2001). Mallon (2001) also noted that GLBTQ youth often face both verbal harassment and physical violence. Based on his research with GLBTQ youth, he stated, “Although violence and harassment may be an unfortunate component of residential care from time to time for all youth, GLBTQ young people, unlike their heterosexual counterparts, are targeted for attack specifically because of their sexual orientation” (Mallon, 2001, p. 79).
PERMANENCY FOR YOUTH IN CARE

Research suggests that there are several issues that affect permanency for older children and youth in the foster care system: the extent to which various permanency goals are identified and planned for youth in care; the extent to which youth’s connections with their families are emphasized; and the stability of permanency arrangements for youth.

Permanency goals for youth in foster care
Nationally, the majority of children and youth in foster care have either reunification or adoption as their permanency goal. In 2001, 44% of children and youth in foster care had a goal of reunification, 22% had a goal of adoption, 8% had a goal of long term foster care, 6% had a goal of emancipation, 5% had a goal of living with relatives other than parents, 3% had guardianship as their permanency goal, and 11% had no goal established (U.S. Department of Health and Human Services, 2003a). The actual discharge destinations of children and youth in foster care, however, vary from the permanency plans that children and youth had while in care. In 2001, for example, more than half of the children and youth who left foster care (57%) were reunified with their parents, 18% left care through adoption, 10% were placed with relatives other than parents, and 3% were placed with families in guardianship arrangements. Importantly, 7% of the children and youth who left care (close to 20,000) were emancipated, and 2% (5,865 children) were considered discharged because they had run away (U.S. Department of Health and Human Services, 2003a).

Data on permanency goals for older children and youth in New York indicate that different permanency goals tend to be assigned depending on the age of the child or youth. Table 7 provides the permanency goals, by age group, for youth in foster care in New York City as of December 2002.

Table 7: Permanency Goals for Youth in New York City Foster Care by Age Group (December 2002)

<table>
<thead>
<tr>
<th>Goal</th>
<th>Ages 12-14</th>
<th>Ages 15-17</th>
<th>Ages 18 and Older</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reunification</td>
<td>47.5%</td>
<td>40.1%</td>
<td>14.8%</td>
</tr>
<tr>
<td>Adoption</td>
<td>40%</td>
<td>14.5%</td>
<td>3.7%</td>
</tr>
<tr>
<td>Independent living</td>
<td>6.9%</td>
<td>32.4%</td>
<td>73.8%</td>
</tr>
</tbody>
</table>

(New York City Administration for Children’s Services, 2003a)

As is the case nationally, the actual permanency destinations of youth in care in New York City differ from the permanency goals assigned to youth at some point during their stays in foster care. Table 8 provides the permanency destinations for youth who entered foster care in 2001 and who were discharged from care as of December 2002.)
In the field of child welfare, there has been growing concern about the use of long-term foster care and/or independent living as permanency goals for youth. Long term foster care and independent living were recognized in the past as acceptable permanency options for older children and youth in care, but recently they have been questioned, at least to the extent that they are used as “across the board” plans for older children and youth (Landsman & Malone, 1999). Research indicates that long-term foster care is associated with psychological harm to children and youth and behavioral problems (Doran & Berliner, 2001) and makes clear the negative outcomes for youth who age out of foster care (discussed later in this research literature review). This recognition led Congress, when it enacted The Adoption and Safe Families Act (P.L. 105-89), to delete long-term foster care as an accepted permanency option (Renne, 2002). Similarly, the federal Foster Care Independence Act of 1999 (P.L. 106-169) rejected “independent living” as a permanency goal, stating, “independent living programs are not an alternative to adoption…Enrollment in independent living programs can occur concurrent with continual efforts to locate and achieve placement in adoptive families for older children in foster care” (P.L. 106-169, 101(a)(2)). Nonetheless, it appears that long term foster care continues to be used as a permanency goal for many youth in care, often in conjunction with a goal of “independent living” (Wattenberg, 2001; Ansell & Kessler, 2003).

Concerns about the inappropriate use of long term foster care and independent living as permanency goals for youth also have been raised in New York City. ACS (2001) has focused on the extent to which youth are being discharged to live “independently.” ACS found that in June 2000, 3,122 children who were in foster care for the first time had a permanency goal of independent living. A large majority of these youth were 16 or older (83%), most had entered foster care between the ages of 6 and 13 (57%), and the majority had their permanency goal changed to independent living when they were between the ages of 14 and 18 (81%). In mid-2003, ACS issued a policy restricting the use of independent living as a permanency goal for youth in foster care. Under the new policy, effective July 1, 2003, ACS must approve independent living as the permanency goal for youth. Depending on the age of the youth, this goal may not be assigned without the prior written approval by the ACS Deputy Commissioner or his or her designated delegate for youth 15 or younger or from an ACS case management supervisor or field office child protective manager for youth 16 or older (New York City Administration for Children’s Services, 2003b). The new policy further requires family-based concurrent plans for youth with goals of independent living – plans that ensure that youth have permanent family connections through reunification with parents, discharge to extended family members, or adoption (New York City Administration for Children’s Services, 2003b).

Adoption as an option for adolescents has continued to be the subject of much debate (National Resource Center on Youth Development, 2000). Professionals differ in their perceptions of adolescents’ acceptance of adoption as a permanency plan and in their views of the willingness of families to adopt teens (Garthwait &
Horejsi, 1992; Lewis & Heffernan, 2000). Data indicate that children’s and youth’s opportunities for adoption decrease as they get older (Wertheimer, 2002). In 2001, for example, national data show that children in care between the ages of 11 and 15 represented 28% of adoption-eligible children but only 16% of all adoptions, and youth between the ages of 16 and 18 represented 4% of the adoption-eligible population but only 2% of all adoptions (U.S. Department of Health and Human Services, 2003a). In response to concerns about this issue, there has been greater focus on developing policies and practices that recognize the importance of permanency for adolescents and that support adoption as an option for youth (Lewis & Heffernan, 2000). Research, however, suggests that barriers to adoption remain. Landsman and Malone (1999), for example, found that even when adolescents were freed for adoption, they faced several barriers to permanency with adoptive families: negative assumptions on the part of child welfare workers about youth’s “adoptability,” time lost because of sequential case management, lack of families willing to adopt older children, and limited resources for pre- and post-placement services.

In addition to the focus on adoption, emphasis recently has been placed on the use of guardianship as a permanency option (Cornerstone Consulting, 2001), particularly for youth who do not wish to be adopted or who are placed with a family member or friend and are maintaining a relationship with birth parents (Roberts, 1999). Some states have established subsidized guardianship programs or revised existing programs to support guardianship arrangements (Cornerstone Consulting, 2001). Data, however, are limited at this point with regard to the use of guardianship as a permanency option, in general, and as an option for youth in care, in particular.

Finally, only limited attention has been given to youth who run away and who may ultimately be discharged to AWOL status with no permanency plan in place. There is little in the literature that addresses the reasons that youth run away from foster care or the characteristics of youth who are likely to run. A recent study by Nesmith (2000), however, found that the youth who are more likely to run after entering foster care:

- are older;
- have run away in the past (these youth are 92% more likely to run than youth without such histories);
- have a permanency goal of “other” as opposed to reunification; and
- are placed in settings that are assessed as being of lower quality.

Based on her findings, the researcher concluded that running behavior is not interrupted by foster care placements and that older youth aging out of foster care may run to trigger a caring response from adults (Nesmith, 2000). These findings suggest that running behavior is related to the quality of permanency planning and youth’s connections with caring adults, an area on which research has not specifically focused (Nesmith, 2000).
Factors affecting permanency
Research indicates that there are differences in permanency outcomes for youth based on age, race/ethnicity, and the reason that youth enter care. With regard to age and race, studies show that older children and black children are at a greater disadvantage with regard to achieving permanency. One study found that the lowest rates of family reunification occurred among children who entered foster care either as infants or adolescents, and among children and youth who were black (Taussig, Clyman, & Landsverk, 2001). In a study of 3,873 children under the age of six who entered foster care in California, Barth (1997) found that the white children in the sample had significantly higher rates of both adoption and reunification than the black children. When adoption was the permanency goal, race appeared to have a significant impact on the achievement of permanency. Black children tended to wait longer to be adopted, if they were adopted at all (Barth, 1997). Research further suggests that black children stay in foster care longer than white children and that black children and other children of color have fewer contacts with their biological families while in care (Fein & Maluccio, 1992). The combination of fewer visits between children and families of color and a high level of unmet service needs has been found to seriously undermine the reunification process (Fein & Maluccio, 1992).

Research also suggests that the reason that youth enter care affects permanency. A study by the Vera Institute for Justice (2001) found that although the majority of children under age 10 entered foster care in New York City because of abuse and neglect (90%), less than one-third (29%) of youth ages 11 through 15 entered for that reason. Youth ages 11 through 15 usually entered care because of a PINS petition or a voluntary agreement. The researchers found that youth who entered on a PINS petition tended to return to their families quickly, with a median stay in care of two months. One-quarter, however, reentered care shortly thereafter, and repeat stays tended to last considerably longer than initial stays. Youth who were voluntarily placed in care by their parents and youth who entered care because of abuse and neglect stayed in foster care for longer periods of time, but they were less likely to reenter care once they returned to their families. Of note is the finding that a large majority of all youth who returned to care were in congregate care at their first placements (66%) and an even higher percentage (79%) entered congregate care at the start of their second placements. The majority of “repeaters” spent all of their time in congregate care (Vera Institute for Justice, 2001).

Family connections and permanency
The literature highlights adolescence as a critical period of self-development, and emphasizes that a key component of healthy development is the formation and maintenance of quality relationships with adults (Hair, Jager, & Garrett, 2002; National Resource Center for Youth Development, 2000). Recent literature has focused on the use of mentors and role models to help youth bridge the transition to adulthood and support the development of strong teen-adult relationships that can provide a foundation for the young person’s psychological health, successful academic performance, and success in later marriage and family relationships (Hair, Jager, & Garrett, 2002). Poorer outcomes – both in terms of psychological well-being and subsequent involvement with the juvenile and criminal justice systems – have been associated with the absence of quality adult relationships in young people’s lives (Hair, Jager, & Garrett, 2002; National Resource Center for Youth Development, 2000).
For youth in foster care, these issues are particularly critical because family separations and placement disruptions have been found to hinder the development of enduring bonds with adults (Hair, Jager, & Garrett, 2002). Research indicates that youth in care wish to maintain connections with their families. A study by McMillen and Tucker (1999), for example, found that irrespective of whether the permanency goal was return to family, many youth went to live with relatives after release or upon running away from care. Consistent with other research, McMillen and Tucker (1999) found that one quarter (26%) of the youth formerly in care were living with relatives after discharge, with 10% of the youth in this group in “unplanned placements” with their relatives (that is, they either ran away or the agency could locate no other placement for them).

Research suggests that youth in congregate care, compared to youth in family settings, have fewer opportunities for ongoing family and adult connections. The NSCAW (2002) found that children and youth in congregate care had the lowest levels of contact with their biological families (children and youth in kinship care had the highest levels of contact and children and youth placed with unrelated foster families had levels of contact that fell between that for youth in kinship care and that for youth in congregate care). NSCAW (2000) found that youth in group care were more likely to report never seeing their biological fathers or mothers. When compared to children in family foster care, children in group care were 3 times more likely to report seeing their birth mother less than once a month. When compared to children in kinship care, they were 4 times more likely care to report seeing their birth mothers less than once a month. In addition, children and youth in congregate care were more likely than children in other types of care to report that visits with family members were cancelled by their caregivers (NSCAW, 2002).

With respect to family connections and permanency, there are several issues that the research literature has addressed in New York City: the extent to which efforts are made to connect youth with family or caring adults; the use of Service Plan Reviews to engage parents and support ongoing contacts between family members and youth; parent-youth visits; neighborhood-based care; and sibling connections.

**Connections with family**

A 2001 study by the Youth Advocacy Center (YAC) (2001a) found that insufficient attention was being given in New York City to teens’ relationships with family members and interested adults when youth were in foster care. The YAC noted that upon a change of a teen's permanency goal to independent living, permanency planning efforts – particularly work with families – ended. Youth who were interviewed by YAC reported that foster care staff showed little interest in helping them maintain relationships with family members or interested adults, and that docking of visits and phone calls with family often occurred as punishment (Youth Advocacy Center, 2001a). These issues have been addressed in the new ACS policy mandating family-based concurrent plans for youth with permanency goals of independent living (discussed earlier).

**Participation in Service Plan Reviews**

The research literature has focused to some extent on Service Plan Reviews (SPRs) as an opportunity for fostering family connections for youth in care in New York City. These meetings, convened by ACS and/or the private agency providing the child’s or youth’s care and held 90 days after placement and every 6 months while a child is in foster care, provide opportunities for parents and other family members to engage in
discussions about the appropriateness of the foster care placement and any progress that has been made toward achieving the assigned permanency goal. The New York State Office of Children and Family Services (2000), however, found in 1999 that these goals were not being well achieved through SPRs. In the OCFS study, researchers found that in 11% of cases, no SPR was conducted, and in 6% of cases, it could not be determined whether a SPR had been held. Importantly, in less than one-third of the cases when a SPR was held did a parent, guardian, or relative attend. In 36% of cases, the reason for the absence of parents and other key adults was not documented. Only 22% of children 10 years or older attended their own SPR. In its August 2003 report, the New York City Child Welfare Advisory Panel expressed concerns about the level of parent attendance at SPRs and recommended that efforts continue to increase parents’ attendance and improve their active participation in SPRs.

**Parent-youth visits**

The literature makes clear that frequent, regular visits between children in foster care and parents are critical to eventual reunification (Office of NYC Public Advocate and C-Plan Child Planning and Advocacy NOW, 2001). Research, in fact, indicates that parent-child visits are the best predictor of family reunification (Special Child Welfare Advisory Panel, 2002). According to OCFS, however, required visits between children in care and their parents do not occur regularly, and that even among children with a goal of reunification, visits are often missed. OCFS reviews indicated that over a 6-month period in 1999, only 29% of the children with a goal of reunification had the required minimum biweekly visits with a parent and most (77%) had only “sporadic” visits (New York State Office of Children and Family Services, 2000). The New York City Child Welfare Advisory Panel, in its August 2003 report, noted that the ACS visiting guidelines “were very good” but did not provide data on the extent to which visits between parents and youth actually were occurring.

**Neighborhood-based services**

One effort to promote reunification in New York City has been the implementation of neighborhood-based services. The literature suggests that family participation (that is, the involvement of parents, extended family, godparents, neighbors, and friends) is much easier when children are placed in care in their own communities (Special Child Welfare Advisory Panel, 2002). In addition, when children in neighborhood-based foster care return home, they can maintain connections with the people they met and continue the services they received while in care. The placement of children with foster families within their own neighborhoods became an ACS policy priority in 2000, and data indicate that the number of children and youth placed in their own communities has grown, although youth in congregate care have not benefited as fully from this effort as children and youth in family-based care (Special Child Welfare Advisory Panel, 2002). Children placed in congregate care facilities have had lower in-borough placement rates than those placed in family-based care (New York City Administration for Children’s Services, 2001), largely because a large percentage of congregate care facilities are located outside New York City. The in-borough placement rate for youth in congregate care has ranged from a low of 8% for youth placed in care from Manhattan to 23.4% for children who are placed in care from the Bronx (New York City Administration for Children’s Services, 2001).
Sibling connections
Another important aspect of family connections is that of sibling placement and/or contact. In some states, siblings in foster care must be placed together, and in other states, there is a strong preference that siblings be placed together (Maluccio, Ainsworth, & Thoburn, 2000). New York law requires that children be placed with siblings unless it “would be contrary to the best interests of the children” (New York State Consolidated Laws, 2003; New York City Administration for Children’s Services, 2001). The literature supports the placement of siblings together for a variety of reasons: siblings are a primary source of emotional and social support to one another; placement together maintains a semblance of a family for children and helps promote the sense that they belong together; placement with siblings reduces the level of separation that children experience when they enter care; and placement together can reduce the significant worry and longing for one another that siblings who are separated often experience (Staff & Fein, 1992; Elstein, 1999). Research indicates that placing siblings together enhances social skills and social competence and decreases the risk of emotional disturbance and disruptiveness in school (Staff & Fein, 1992).

Data indicate, however, that siblings often are not placed together (Hegar, 1988). Hegar (1988) found that siblings in foster care who were most likely to be separated were older, were members of larger sibling groups, had developmental disabilities, were placed in residential institutions or schools, or came into custody at different times. Drapeau, Simard, Beaudry, and Charbonneau (2000) also found that siblings were more likely to be separated when they were older and when a larger age gap existed between siblings. They also found that sibling separation resulted in greater placement instability for the children.

In its study released in 2000, OCFS found that 87% percent of children in foster care in New York City had one or more siblings, many of whom were in care at the same time. The New York State OCFS report indicated that 46% of children with siblings in foster care were placed with all of their siblings; 29% were placed with some, but not all siblings; and 25% were not placed with any of their siblings. According to OCFS (2000), in 77% of the cases in which siblings were not placed together, either there were “compelling” reasons to place them apart or the caseworkers’ attempts were not successful at placing the children together. Siblings in separate placements, however, often did not see one another for more than six months. In more than half (56%) of the cases, children did not have biweekly visits with siblings during a six-month period of time.

As Table 9 indicates, recent New York City data indicate higher rates of sibling placements together when children are younger, with the lowest percentage of placement together occurring for teens.

Table 9: Percentages of Siblings Placed Together by Age Group (2001)

<table>
<thead>
<tr>
<th>Age Group</th>
<th>All Placed Together</th>
<th>Partly Placed Together</th>
<th>Placed with No Sibling</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-5</td>
<td>65.2%</td>
<td>26%</td>
<td>8.8%</td>
</tr>
<tr>
<td>6-11</td>
<td>71%</td>
<td>24.2%</td>
<td>4.9%</td>
</tr>
<tr>
<td>≥12</td>
<td>53.3%</td>
<td>26.4%</td>
<td>20.3%</td>
</tr>
</tbody>
</table>

(New York City Administration for Children’s Services, 2003a).
The likelihood of siblings being placed together also appears to depend on the type of placement that is utilized (New York City Administration for Children’s Services, 2001). According to ACS data for 2000, 86% of siblings placed with kin were placed together; 75% of siblings placed with unrelated foster families were placed together; and only 42% of siblings were placed together when congregate care was used (New York City Administration for Children’s Services, 2001).

**Stability of permanency arrangements**

Research strongly suggests that age affects the stability of permanency arrangements. The impact of older age on permanency arrangements – whether reunification, placement with relatives, or adoption – suggests that for adolescents and their families, permanency arrangements may be vulnerable to disruption. With regard to the stability of reunification, research indicates that between 3% and 27% of children discharged to their families after their first stays in foster care return to foster care (U.S. General Accounting Office [GAO], 1991). Several studies have found that reentry following reunification is associated with children's older ages at the time they enter foster care and their older ages when they are discharged home (Children and Youth Interagency Management Information System, 1990; Fein, Maluccio, Hamilton, & Ward, 1983; Festinger, 1996). Similarly, preliminary assessments of the stability of placements with kin indicate that these arrangements disrupt at a rate of between 10% to 16% (Barth, Gibbs, & Siebenaler, 2001). Research suggests that kinship placements may disrupt for a variety of reasons, including adolescents’ difficulties in adapting to life with their relatives after they have lived with parents who, in many cases, were substance involved; and adolescents’ difficulties in adjusting to family life after their experiences in foster care (Terling-Watt, 2001).

Barth and Berry (1988) also found that the risk of adoption disruption was higher for children placed with adoptive families at older ages. The rate of adoption disruption has been reported to range from 10% to 12% for all children who are placed for adoption when they are older than 3 years, with somewhat higher disruption rates – approximately 14% – when children are placed for adoption between the ages of 12 and 18 (Barth & Berry, 1988). Research further suggests that adoption disruption rates for children with physical, mental health and developmental problems range from approximately 10% to 25% (Festinger, 1990; Berry, 1997; Goerge, Howard, Yu, & Radomsky, 1997). The fact that older age at time of adoption is associated with a greater risk of attachment disorders and behavioral problems – given prolonged separations from families and, for many children, multiple placements while in foster care – appears to increase the risk of adoption disruption (Landsman, Malone, Tyler, Black, & Groza, 1999).

Although not extensive, the literature is beginning to address the post-permanency services needs of families, whether the arrangement is reunification, placement with kin, or adoption (Freundlich & Wright, 2003). Post-permanency services primarily have been developed to meet the needs of adoptive families, but there is increasing awareness of the need to support families after reunification and to support kinship families. Given the particular challenges associated with achieving and sustaining permanency for adolescents, these services are being recognized as extremely important (Freundlich & Wright, 2003).
YOUTH INVOLVEMENT IN DECISION-MAKING

Research indicates that youth are not involved significantly in making decisions that affect them while they are in foster care nor in planning for themselves post-discharge. Studies of youth in foster care in Britain, North America, Australia, and New Zealand have found that most children and young people in foster care feel they do not have many opportunities to be involved in the decision-making process about where they live and how often they see their parents (Cashmore, 2001). A New South Wales Commission for Community Services study (Cashmore & Kiely, 2000) found that 62% of children and teens said they had not been asked where they wanted to live and 47% said that they had no say on issues relating to contact with their birth families. In some cases, youth reported that they had not been told when and why they were changing placements. A British study likewise found that almost all of the 600 young people surveyed felt that there were areas in their lives where they needed more involvement, with nearly half stating that they “felt they had no say in daily decisions” (Fletcher, 1993; Landsdown, 1995a, 1995b). Likewise, in a study of children in foster care in the United States (children with a median age of 12), 40% said they were unclear about why they were in care (Johnson, Yoken, & Voss, 1995). In an Illinois study of 1,100 children, only 29% of the youth in foster care said they had discussed with their caseworkers what their situation would be after they left their families and were living elsewhere (Wilson & Conroy, 1999).

Cashmore’s study (2001) focused on the experiences of youth in foster care who regularly attended case conferences and review meetings in which decisions about their care were being made. Youth described the process as a “frustrating and disempowering experience.” Although the youth were eager to have a say in what happened to them, their expectations were limited - they did not expect to “get their own way” or control the decision-making process (Cashmore, 2001). Nonetheless, they reported that they were not permitted even a minimal role in planning for themselves. A study by Advocates for Children (Chaifetz, 1999) in New York City similarly found that youth in care were not regularly involved in service plan reviews in which plans for them were being discussed. A survey of 54 youth revealed that more than 57% were not invited to the meetings, and 40% of youth who knew about the meetings reported that they were held at an inconvenient time. A large majority of those who knew about the meeting (70%) received notice less than 2 weeks before the meeting, and more than 75% reported that they were not told that they could bring someone with them. More than one-half of the youth who took someone with them to the meeting were told that the individual could not remain (Chaifetz, 1999).

TRANSITIONING FROM FOSTER CARE

Research has addressed a number of the issues that affect youth’s transitions from foster care: health status and access to health care; education; employment; poverty; safety; criminal activity; and housing. It also has addressed, to some extent, the importance of family and adult connections, assessments of the adequacy of independent living preparation, and the public’s perceptions of youth transitioning from foster care to adulthood.

Health status and health care

Research indicates that youth aging out of foster care often need highly intensive and specialized health services. The Texas Foster Care Transitions Project (2001) found that health problems after aging out were
prevalent among youth. In the Nevada KIDS COUNT study (2001), 30% of youth formerly in foster care reported having serious health problems. A study by Barth (1990) of 55 youth formerly in foster care in the San Francisco Bay area found that the youth often either had a depression score above clinical level or had been admitted to a hospital for in-patient mental health services. Another study concluded that youth formerly in foster care experienced more psychological distress than their peers who had not been in foster care (Youth Advocacy Center, 2001b). Likewise, the Texas Foster Care Transitions Project (2001) found that youth who aged out of foster care often reported mental health issues, particularly feelings of fear and loneliness.

Studies indicate that youth who leave foster care, although needing health care services, often lack information about how to obtain the services they need. Marsenich (2002), for example, reported that youth often found that the information made available to them on mental health issues and services was inadequate. Other studies indicate that even when youth know about services, they often lack the resources to obtain needed services. One study found that only 21% of youth in foster care reported receiving mental health services post-care, a drop from the 47% who received services while in care, because they could not afford the services (Courtney, Pilavin, Grogan-Kaylor, & Nesmith, 2001). Many youth leaving care enter into jobs that do not provide health insurance or pay too little for them to be able to afford independent health care coverage. The Texas Foster Care Transitions Project (2001), for example, found that lack of health insurance deterred youth from seeking the attention they needed.

The poor health status of many youth who leave foster care also places them at risk of a number of other poor outcomes. Youth with physical and mental health conditions and disabilities have been found to have the lowest rates of high school graduation, achievement of post-secondary education, and full-time employment (National Foster Care Awareness Project, 2000).

**Educational outcomes**

Research indicates that youth who age out of foster care tend to be at an educational disadvantage. Mech (1994) aggregated four studies of youth entering adulthood from foster care and found that the average high school completion rate among them was 58%. National estimates of the percentage of youth in foster care who leave care with a high school diploma range from 37% to 60%, depending on the size of the population studied and other research constraints (Burley & Halpern, 2001). The results of several recent studies on the educational outcomes for youth in foster care include the following:

- A report published in Child Trends (2002) found that less than half (48%) of youth who aged out of care in 1998 had graduated from high school (Hair, Jager, & Garrett, 2002).
- The Washington State Department of Social and Health Services Children’s Administration found in its study of youth age 18 or older who left foster care between January and June 2000 that only one-third (34%) of youth had a high school diploma or GED (Burley & Halpern, 2001).
- The Youth Advocacy Center (2001b) found that two to four years after aging out of foster care, only about 50% of youth had completed high school or received a GED and only 9% had entered college.
• McMillen and Tucker (1999) found that 39% of youth aging out of foster care had a high school degree or GED, and 64% were progressing toward a high school degree.

These statistics suggest very poor educational outcomes for youth when compared to U.S. Census Bureau (2000) data that indicate that 84% of all young adults in the U.S. between 25 and 29 years of age have high school or high school equivalency diplomas.

Research also indicates that many youth who leave foster care have learning challenges that further complicate their ability to live on their own. Reading, auditory, and attention problems have been found to undermine the ability of many youth to succeed in school or benefit from independent living preparation (National Foster Care Awareness Project, 2000). In addition, the Youth Advocacy Center (2001b) found in its study that many teens in foster care reported having few role models who could assist them in understanding the value of education or work experience as they prepared for adulthood.

**Employment outcomes**

Youth who age out of foster care also appear to face unemployment and underemployment in significant numbers. In the study by Courtney, Pilavin, Grogan-Kaylor, and Nesmith (2001), 40% of the youth who were interviewed 12 to 18 months after leaving foster care were unemployed. The young people who were employed earned an average salary that was less than the wages of a full-time worker receiving minimum wage (Courtney, Pilavin, Grogan-Kaylor, & Nesmith, 2001). The Chapin Hall Center for Children at the University of Chicago also found that youth aging out of foster care had high rates of unemployment: 30% of the youth who aged out of foster care in Illinois were unemployed; 23% of the youth in California were unemployed; and 14% of the youth in South Carolina left care without a job (Goerge, 2002). The study further found that youth often were underemployed. Youth aging out of foster care were found to have mean earnings below the poverty level, and they were found to earn significantly less than youth in any of the comparison groups both prior to and after their 18th birthdays (Goerge, 2002). Similarly, the Youth Advocacy Center (2001b) study found that only one-half of youth maintained stable employment two to four years following discharge from foster care. McMillen and Tucker (1999) found somewhat better outcomes regarding employment for youth who aged out of foster care. These researchers found that 38% of the youth had jobs and 66% had some employment experience, an outcome that they attributed to the recent emphasis on providing youth with independent living skills.

Similar to other studies, Dworsky and Courtney (2000) found that 21% of youth formerly in foster care in Wisconsin who exited foster care between 1995 and 1997 were unemployed, and 24% had been sporadically employed in the 2 years following discharge. They also found that youth of color were far more likely to be unemployed than whites, and youth discharged from institutions were more likely to be unemployed than those discharged from family foster care. Total earnings among youth in their sample were, on average, substantially lower than full-time minimum wage earnings, and African American youths earned less than whites.
Poverty

Because of poor employment outcomes, youth who age out of foster care are at higher risk of poverty (National Foster Care Awareness Project, 2000), and, as a result, many youth rely on public assistance at different points in time (Youth Advocacy Center, 2001b; Courtney, Piliavin, Grogan-Kaylor, & Nesmith, 2001). Courtney and colleagues (2001) found that among youth who had been out of care between 12 and 18 months, 32% had received some form of public assistance since leaving care (40% of the females and 23% of the males). Close to one-quarter (23%) of the females (but no males) had relied on AFDC or TANF; 20% of females and 2% of males had obtained food stamps; 12% of females and 12% of males had received SSI; and less than 4% of both females and males reported relying on other assistance such as “general assistance” or housing assistance. Barth (1990) also found that many of the youth in his study had faced extreme financial hardship after exiting care: one-half had serious money problems, including not being able to buy food or pay bills. One-third reported that they had done something illegal to obtain money (such as stealing, prostitution, or selling drugs). Similarly, in the KIDS COUNT study in Nevada (2001) involving 100 youth who had been out of care for at least 6 months, researchers found that 41% did not have enough money to cover basic living expenses, 34% earned less than $5,000 in 1999, and 60% earned less than $10,000 in that same year.

Safety issues

Research indicates that youth who leave foster care are at risk of victimization. According to Courtney and colleagues (2001), 25% of males and 15% of females experienced serious physical violence (such as beatings and attacks), and 13% of females experienced sexual assault and/or rape in the 12 to 18 months period following discharge. Data also indicate that youth with learning disabilities (which studies suggest affect many youth who age out of foster care) are at greater risk of sexual abuse victimization (National Foster Care Awareness Project, 2000).

Criminal activity

Courtney and colleagues (2001) found that 18% of the youth who participated in their study had been arrested at least once since discharge and that 27% of the males and 10% of the females had spent time in jail. One third of the respondents in the Barth (1990) study of youth formerly in foster care in the San Francisco Bay area had been arrested in the previous year, and 26% had spent time in jail or prison. The Nevada KIDS COUNT study (2001) found that 24% of youth formerly in foster care had engaged in criminal conduct to support themselves. Forty-five percent had been in trouble with the law, with 41% of this group having spent time in jail (Nevada KIDS COUNT, 2001). The 1991 Westat study similarly found that 40% of the males who had exited foster care had spent time in jail (Cook, 1991).

Homelessness

Studies further suggest that youth who age out of foster care often face homelessness (Texas Foster Care Transitions Project, 2001). In the study by Courtney and colleagues (2001), 14% of the men and 10% of the women reported being homeless at some point during the first 12 to 18 months following discharge from foster care.

In its 1999 report, the Citizens’ Committee for Children (CCC) found that a significant number of youth aging out of care were discharged to homeless shelters even though that practice is prohibited by New York
State law. The CCC’s study (1999) of 10 foster care agencies found that 17% of youth leaving care were discharged to a shelter. Covenant House, also based in New York City, estimated in 2001 that there were approximately 20,000 runaway and homeless young adults ages 18 to 21, a figure that included 5,400 young adults suffering from a psychiatric disorder (1,700 of whom were severely mentally ill). One-third of the homeless youth had spent time in foster care. In its analysis of both the number of homeless young people affected by psychiatric problems and the severity of their problems, Covenant House cited as a leading cause “an increased number [of youth] coming out of foster care without case planning” (Guinn, 2001, p.6). The problem of homelessness for this group was attributed to a shortage of age-appropriate supportive housing, and the absence of housing reserved specifically for youth aging out of foster care (Guinn, 2001).

**Family connections**

It is clear from the research on youth aging out of foster care that a large percentage of youth either return home or, at minimum, maintain connections with birth or foster families after discharge (Barth, 1990; Cook, 1991; Courtney, Pilavin, Grogan-Kaylor, & Nesmith, 1998). The research indicates that youth pursue these connections irrespective of whether they receive support while in care to maintain these connections (Barth, 1990; Cook, 1991). As discussed earlier, however, research has shown that family and significant persons in the lives of youth have limited or no involvement in the permanency planning process (see Landsman, Malone, Tyler, Black & Groza, 1999). When youth return home after aging out, they often lack the coping skills they need to manage problems that arise at home (Loman & Siegel, 2000).

**Adequacy of independent living preparation**

The research literature has addressed the overall quality of independent living preparation and strategies for improving these services.

The overall quality of independent living preparation

Research has suggested that although youth who age out of foster care often reported that they received some preparation for independent living, they also indicated that the preparation that they received was uneven, and in spite of the independent living services that they received, they often did not feel prepared for life on their own after exiting care. One study of youth’s transitions from foster care to adulthood, for example, found that 85% of the youth respondents said that they had been educated about personal health care, job-seeking, and decision-making skills, but fewer than 70% had been trained in money management, legal skills, parenting, and how to use community resources (Courtney, Pilavin, Grogan-Kaylor, & Nesmith, 2001). The study found that the independent living training programs often did not involve youth in “real-life” activities, and youth stated that they felt unprepared to find housing, live on their own, and deal with health issues (Courtney, Pilavin, Grogan-Kaylor, & Nesmith, 2001). Research also suggests that some percentage of youth find the challenges of being in foster care to be so great that they do not make use of the services that are available—removing themselves from the system before turning 18 and neglecting to make long-range plans (Texas Foster Care Transitions Project, 2001).

In the study by the Youth Advocacy Center (2001b), many teens reported that independent living workshops did not provide a serious learning environment and that greater emphasis was placed on field trips and games than on workshops focused on life skills. The teens reported that the themes of many independent living workshops related to substance abuse and sexually transmitted diseases and that few
workshops addressed education, career planning, or relationship building. The Youth Advocacy Center (2001b) concluded that youth needed individually tailored independent living services and plans, but they rarely received such assistance. In some cases, independent living programs were not offered at all because the youth were thought to be unable to achieve “independence” (Youth Advocacy Center, 2001b). Studies of the quality of independent living services for youth in New York City indicate similar problems. One study found that less than half of youth with a goal of independent living received the required services and training, and in two-thirds of the cases in which youth were required to be informed of the availability of family planning services, they were not (New York State Office of Children and Family Services, 2000).

Some writers have been quite critical of independent living programs. These observers state that independent living programs create unreal and unfair expectations on the part of youth, foster parents, and practitioners; underestimate the importance of youth’s needs to connect with others; and place the burden of preparing for adulthood on the youths themselves (Maluccio, Krieger, & Pine, 1990). Some writers, such as Iglehart (1994), have urged that programs go beyond the skills and training provided to youth as preparation for independent living and focus instead on placement disruptions, psychological/mental health problems, and the length of time in foster care that undermine adequate preparation of youth for life after they exit care. At the same time, however, Iglehart (1994), Westat (1986), and Waldinger and Furman (1994) have emphasized that the youth who are better prepared for independent living are those with higher levels of educational attainment and labor force experience and who are in contact with their birth families.

In New York, independent living services are offered to youth 14 years and older who have a goal of independent living. In 1987, the New York State Department of Social Services set guidelines for independent living services that required local social service districts to provide 16 hours of life skills classes annually and vocational training to prepare youth for self-sufficiency. In a CCC study, it was found that only 46% of eligible youth received ongoing vocational training even though it was required for all eligible youth (Citizens Committee for Children, 1999). In addition, New York State regulations require that every youth in care age 16 or older receive a monthly independent living stipend. In a sample of 74 teens, however, the New York State Office of Children and Family Services found that only 43 teens were receiving their stipends (cited in Citizens Committee for Children, 1999). According to ACS, several changes have been made in the Independent Living Program to address these issues.

**Strategies for improving independent living preparation**
The literature contains recommendations for improving the quality of independent living services, both generally and in New York City. In a study of youth who were alumni of foster care, Casey Family Programs (2003) asked the young adults to describe the factors that were crucial to success when they left foster care. The young adults emphasized the need for transition services as a “buffer”; the importance of making higher education available for youth who wanted it; the availability of ongoing services to support youth beyond the age of 18; and no time limits so that needed resources could be obtained at any time after youth left foster care. The young adults focused on the importance of receiving information on the types of financial assistance that may be available to them as they leave foster care – cash payments, opportunities to learn how to manage money, coaching resources regarding money management, and money skills development.
In New York City, ACS requires private agencies to meet four goals for youth discharged from foster care. In order to be discharged, youth are to have medical coverage in place, at least an eighth grade competency in reading and math, a job (or be enrolled in full-time post-high school education), and adequate housing. After reviewing the failure of independent living services to achieve these goals for youth in foster care, the CCC (1999) recommended that independent living programs be redesigned. The CCC (1999) recommended a number of changes to ensure that each youth has a job, a high school degree, and health insurance when leaving care and that programs provide, in addition to life skills classes, real-world experiences such as opening and using a bank account, internships, and job experience.

Similarly, based on its study, the Youth Advocacy Center (2001b) made recommendations to improve independent living services. It emphasized employment for teens age 16 and over. Based on the view that independent living programs should focus on teens’ futures and their potential for success rather than on their past experiences, the Center recommended three concrete changes to current independent living programs: support for “self-advocacy education” (an approach centered on setting long-range goals and enhancing self-esteem and interpersonal skills in order to actualize those goals); custodial arrangements that support teens as they develop detailed plans for the future; and exploration of non-traditional placement alternatives for teens in care.

The public’s perceptions of youth transitioning from foster care
Although research is limited, the literature indicates that the general public has little awareness of the issues affecting youth who are transitioning from foster care but that, among those individuals with an awareness of these issues, there is significant concern. The Jim Casey Youth Opportunities Initiative (2003) conducted a nationwide telephone survey and focus groups to ascertain the public’s knowledge of and perceptions about the challenges facing young people leaving foster care. The key findings were: (1) most Americans stated that they knew little about foster care and they had mixed opinions about how well the foster care system serves those in its care; (2) most Americans believed that age 18 is too young for young people to be completely on their own (whether they are leaving foster care or not); and (3) the large majority (93%) of respondents believed that the provision of transitional programs for youth leaving foster care is important. Large majorities endorsed the following elements of transitional programs for youth in foster care: training on managing and saving money (98%), involvement of youth in planning and making decisions for their own futures (98%), and facilitation of youth’s connections with individuals (97%) and institutions (96%) in their own communities (Jim Casey Youth Opportunities Initiative, 2003).

SUMMARY

The current knowledge base regarding youth in foster care provides a context for understanding the experiences of youth in congregate care in New York City. These youth, like youth in foster care across the United States, are principally youth of color and many have been in foster care for extended periods of time. The information provided in this review of the research literature provides a synthesis of the current knowledge base on the six substantive domains of this study – placements, services, safety, permanency, youth involvement in planning and decision-making, and transitioning from care. The findings, presented in the next section of this report, build on this knowledge base.
This section of the report presents the findings from interviews with professional stakeholders and with young adults. The findings from the interviews with professionals are presented first, followed by the findings from the interviews and focus groups with young adults. With regard to the professional stakeholders, the analysis identified the themes that arose across all professional stakeholder groups in an effort to find consensus positions and distinct differences on the critical issues. With regard to the young adults, the analysis identified themes of agreement or disagreement on critical issues solely within that group. In all cases, quotes were selected to fairly represent the range of viewpoints expressed on any one issue or to illustrate, in as balanced a manner as possible, differences in perspectives. When a position represented an interesting but unique viewpoint, the findings so reflect. For both groups of stakeholders, the findings are organized according to the domains on which the study focused: congregate care as a placement resource for youth; services for youth in congregate care; safety issues in congregate care; permanency planning and permanency outcomes for youth in congregate care; youth involvement in planning and decision-making; the transition of youth from foster care; and recommendations for strengthening foster care for youth.

FINDINGS FROM INTERVIEWS WITH PROFESSIONAL STAKEHOLDERS

Five professional stakeholder groups were interviewed in this study: judges, law guardians, social workers, representatives from private agencies (“agency representatives”), and representatives from advocacy and other relevant organizations in New York City (“organizational representatives”). The following summarizes the findings from these interviews.

CONGREGATE CARE AS A PLACEMENT FOR YOUTH IN FOSTER CARE

Respondents discussed several issues regarding the use of congregate care as a placement resource for youth in foster care:

- The extent to which congregate care is and should be a placement resource for youth in care;
- Variability in the quality of congregate care facilities;
- The need for individualized decision-making in congregate care placements;
- The need for a broader range of placement options for youth in care;
- The placement needs of special populations;
- Systemic issues that impact the quality of congregate care; and
- The staffing of congregate care facilities.

The role of congregate care as a resource

Respondents expressed a variety of views regarding the value and appropriateness of congregate care as a placement resource for youth in foster care. Some respondents focused on the benefits of congregate care placements. Of all stakeholder groups, agency representatives were more likely to highlight these benefits, but some social workers and organizational representatives also stated that congregate care is an important placement resource for youth. Among the observations of agency representatives were the following:
“At times, teenagers can learn new types of behavior from other teens who may have some difficulties but may also have strengths in some areas. These teens can flourish better in a congregate care environment.”

“There is a significant number [of adolescents] for whom a residential institution is the best place because you can care for them 24/7. Institutions can be good, stimulating, and stable environments for adolescents. Family or group homes probably couldn’t do this.”

Among those social workers who saw congregate care as beneficial for teens, the key aspects of congregate care that they favored were the opportunity that it provides for youth to build peer relationships and to be with people their own age, and the stability that congregate care offers as a result of clear rules and expectations. Some organizational representatives also stated that congregate care offers benefits not available through family-based care. Among their comments were:

“…Some of the kids feel much better about being in a foster home and other kids feel much more protected when they have a lot of adults in charge of them instead of being kind of isolated with one person — especially if they have had bad experiences in a foster home. Group homes offer teens more opportunities than do foster homes.”

“I think that the youth who haven’t been in group homes are scared of group homes, and they really don’t want to go…But I feel like once someone is in a group home, they usually prefer staying in group homes. For some of them, it’s just too much for them to try to adjust to all these different rules in each foster home and the intimacy of trying to be part of a family. At some point, they’re just kind of sick of that, they’ve become independent.”

The agency representatives who viewed congregate care in highly positive terms often also stated that this type of care was particularly beneficial for certain types of youth, including: youth whose emotional difficulties made it difficult for them to fit into a new foster home; youth with mental health needs who could not be served elsewhere; youth who needed a highly structured environment (such as substance abusers, truants, and behavioral risk-takers); and girls who had experienced sexual abuse and were not ready to live in a new family with men.

Some respondents expressed highly negative views of congregate care as a placement resource. Some agency representatives, for example, described congregate care as a “dumping ground” that does not take the service needs of youth sufficiently into account, as a “warehouse” for disturbed children and youth who need higher levels of care, and as a situation in which “you’ve put together troubled kids without special support. You watch chaos break out.” Several social workers expressed similarly negative views of congregate care, characterizing it as “a terrible option,” “a failure,” and “a dumping ground.” One social worker described group home culture as “disturbing” because youth have very few opportunities to make meaningful connections with adults. Law guardians expressed similar views:
“Congregate care is not a good option because [youth] are traumatized in the first place and then they’re thrown into a situation with a group of people they don’t know. They have almost no privacy. They don’t feel safe a lot of the time, and they have staff that doesn’t particularly care about what goes on.”

“The entire environment is like walking around where there are mines and snipers psychologically.”

“Group homes are not providing [youth] with any better structure in many situations than what they originally came from.”

One law guardian who expressed concerns about the atmosphere in group homes gave the example of a client who had run away on occasion, had not attended school, and had “some attitude.” The youth, however, was not physically aggressive in any way. “He was actually a really nice, likeable kid, very smart and very savvy.” Both of his parents cared about him and had come with him to court each time, seeking help with supervision. The youth was ultimately placed in a group home with teens. He was arrested three times over the next 12 months for involvement in a robbery, possession of a stolen vehicle and assault, all of which involved other residents of the facility.

Respondents from all stakeholder groups also identified the aspects of congregate care that they believed made it a poor option for youth. Collectively, their major concerns were:

- The isolation that congregate care creates because youth are moved far from their families and communities;
- The placement of too many children and youth with overwhelming needs in congregate care facilities (with particular concerns expressed about the mixing of youth with histories of abuse and neglect with youth who enter care on PINS [Person in Need of Supervision] petitions);
- High rates of AWOL; and
- The absence of adequate services.

Although all stakeholder groups expressed concerns about congregate care, only organizational representatives took the position that congregate care should be phased out altogether. One organizational representative stated that congregate care was an “outdated notion” that does not serve families. Organizational representatives who took this position focused on the need to avoid foster care placement altogether whenever possible and on the importance of finding family-based placement alternatives when youth must enter care. Some organizational representatives’ comments in this regard were:

“I believe, sincerely, that when children and families come to the attention of authorities, ACS and the courts and other agencies, there is a tendency to recommend placement as opposed to ‘let’s figure out how we can empower and serve the family, and support the family in their home and community.’”
“There will be resistance [to phasing out congregate care], but we have to show courage in the face of it. And my recommendation is we need far fewer congregate care beds than what exists in New York State today.”

Variability in the quality of congregate care facilities
Some respondents emphasized the considerable variability in the quality of congregate care facilities. Some stakeholders expressed preferences for one form of congregate care over another. Some judges, for example, viewed residential treatment centers (RTCs) more favorably than group homes which they characterized as highly disorganized. In the words of one judge, “RTCs are much better than the group homes, although the kids in each type of facility aren't so different.” Other judges, however, were more skeptical of RTCs. One judge stated, “To me, unless a child is truly, truly ill, and looks as if he's going to be ill for the rest of his life, I like to avoid [RTCs]. Because it puts them on a track to stay in institutions for the rest of their lives.”

Many judges, social workers, organizational representatives and agency representatives stated that group homes and RTCs ranged from good to bad. One judge described congregate care, in general, as a “mixed bag,” with quality varying depending on the particular group home, how many youth were placed there, and which agency operated the group home. One social worker similarly observed that there are some very good group homes and there are others that “no social worker would want to use.” One social worker described very good RTCs and then went on to say, “and then there are others that are just atrocious. In my experience, actually physically being at some of these RTCs and hearing the staff interact with kids is somewhat concerning, seeing that this is supposed to be a residential treatment center with very skilled staff who know the special needs of these particular children and have the patience and skills to deal with them.”

Organizational representatives also observed that the quality of congregate care facilities was highly variable. One stated, “with group homes, it can go either way – some are dorm-like, others are like a jail.” Finally, agency representatives distinguished between good and poor congregate care. In the words of one agency representative, “congregate care works when it's therapeutic. It doesn't work when it's a holding pen for kids that nobody knows what to do with.”

The need for individualized decision-making in congregate care placements
A consistent theme in interviews with all stakeholder groups was concern about the absence of individualized decision-making that results in inappropriate placements of youth in congregate care settings. One judge commented that it was impossible to discern patterns as to which youth “end up where” — in foster homes, therapeutic homes, group homes, or residential treatment centers. “There seems to be a haphazard pattern of placement…with no discernible criteria or protocol for placement.” One organizational representative noted, “I just have been amazed at how many kids are in group homes who don't belong there.”

Several law guardians stated that bed availability, as opposed to the needs of youth, seemed to drive placement decisions. One observed that “when an agency decides the next step is going to be a group home — and usually it's just because it's a last resort, then it's just what group home is going to have a bed most quickly. It has nothing to do, as far as I can tell, with that person's needs.” Social workers commented that congregate care is used as a default placement for all teens without individualized assessments or diagnostic evaluations that inform decisions about the child's placement. One social worker described a situation in which she strongly believed that her client would have benefited from a particular RTC because of its special
therapeutic programming. The RTC, however, required an interview with the youth while another did not. Because no interview was required, the youth was sent to the second facility. “There was no matching whatsoever. It was plugging in a kid to fill a need of the agency, not to fill that client’s individual needs.”

The need for a broader range of placement options
Judges, agency representatives, and organizational representatives often focused on the need for a broader range of placement and service options for youth, the need to use other placement options before resorting to congregate care, and the need to recruit foster families for youth in care. In the words of one organizational representative, “You could have a really, really, really crazy kid living at home or living in the community if they had access to services. If you could do that, you could bring a lot of kids home.” Judges, in particular, expressed concerns about the use of congregate care when family-based care is the better alternative. Their comments included:

“I don’t see a reason for congregate care where a child can do well in a foster boarding home. My experience is that caseworkers view teenagers as a difficult population to deal with and by extension, I assume that foster parents may feel the same way. That is probably why they don’t have enough places for them, why it is hard to recruit foster parents.”

“Ideally, a foster home is best for kids, especially older kids who feel alienated…there are not enough foster homes.”

The placement needs of special populations
Respondents identified several special populations for whom placement resources appeared inadequate: GLBTQ youth, youth with severe developmental disabilities, and youth who are sexually aggressive or who have been sexually abused. Respondents, however, most often mentioned teen mothers and their children. Agency representatives, judges, social workers, and organizational representatives expressed concerns about this population. One judge, for example, commented:

“These [mother-child] placements are good for mature girls who are able to handle the responsibility. But some younger teens, 14-15 with a baby, are very troubled and will try to abscond, either with or without the baby, maybe get arrested. If the girl isn’t relatively stable, the mother-child program is not the right place for her because it allows too much independence.”

Social workers pointed to the separation and isolation that pregnant and parenting young women experience with the placements that typically are arranged for them. One social worker explained that in most cases, young women live in one place while they are pregnant and another place after giving birth. Often, the mother returns to the maternity home while awaiting a mother-child placement after giving birth and is separated from her infant during the child’s first days of life – a situation that one social worker described as “devastating for these kids.” Organizational representatives also expressed this concern and added that teen mothers are often threatened with the loss of their children when group care staff perceive them to be uncooperative. One organizational representative commented, “That is just endemic throughout the system. I haven’t had a single client in this situation come in and not mention that this threat is laid upon her.”
Systemic issues that impact the quality of congregate care
Agency representatives identified several systemic issues that affected the use of congregate care as a placement alternative and the quality of congregate care:

- The pressure on agencies to keep their beds filled which leads to acceptance of youth for whom programs are not appropriate;
- The inability of agencies to reject referrals from ACS even when youth do not fit the characteristics of youth whom the agencies appropriately can serve;
- Inadequate funding for placements and services through both ACS and Medicaid; and
- Inadequate responses from other systems, including the Office of Mental Health and the Office of Mental Retardation and Developmental Disabilities. One agency representative commented that if these systems were “working better,” “child welfare would not need as many congregate care beds. While other systems can ‘say no,’ ACS cannot turn kids away.”

The staffing of congregate care facilities
One consistently expressed concern was the poor quality of staff in congregate care facilities. The reasons given for poor staff quality, however, varied. Agency representatives tended to focus on their inability to provide higher salaries. One agency representative, for example, stated:

“We pay average salary for child care workers. Most work several jobs. Our caseworkers start in the high 20s. We can’t compete with the public agencies. ACS starts workers at $10,000 more. [It’s a] big problem. It goes down to what we’re paid for caring for these children.”

Law guardians, social workers, and judges identified other factors that they believed worked against the quality of congregate care staff. These factors included:

- Staff have few professional qualifications and are inadequately screened.
- Once hired, staff are inadequately trained regarding their roles and responsibilities or about adolescent behavior and the impact of trauma on youth. One social worker stated that agencies hire people “who have no idea how to work with kids”, never having worked with youth or having received any training to do so.
- Staff are poorly supervised and often engage in inappropriate behavior. One law guardian shared reports that refrigerators in congregate care facilities are locked and teens cannot get food, but staff have keys and “pig out in front of them.” Another law guardian reported that staff bring their own laundry to the group homes and use the machines while youth are waiting to do their laundry.
- Staff turnover is high and, in the words of one law guardian, “A lot gets lost.”
Nonetheless, some law guardians commented favorably on some congregate care staff. One said, "when you look for unskilled labor, you're going to get what you pay for, which doesn't mean that there aren't some diamonds in the rough." Another said, "I've also seen staff members be incredibly supportive of young people."

SERVICES FOR YOUTH IN CONGREGATE CARE

Respondents commented on the general availability and quality of services for youth in congregate care and on specific service areas of importance to youth in care.

The general availability and quality of services for youth in congregate care

Three general themes arose regarding the availability and quality of services for youth in congregate care:

- Needed services often are not available;
- The services that are available are not provided based on the individual needs of youth in care; and
- The quality of the provided services is extremely variable.

The respondents who expressed these concerns, however, gave a variety of reasons for the lack of readily available, quality services for youth in congregate care. Agency representatives, more so than other groups of stakeholders, more often focused on inadequate funding. Their comments included the following:

"With extra money, kids do get the services they need. Money from ACS is just not enough."

"Right now, we're not getting what we should because of the budget crisis. [The] State has set the rate, but the City isn't paying it. [This is] true for all foster care programs in the state. We have two options — raising private money or you cut costs."

Law guardians and social workers often pointed to an inattention to youth and their needs as the reason for poor services. One law guardian stated, in reference to the services provided to youth in congregate care, "Let's face it, foster care kids are considered throw away kids. They feel it immediately and they understand it." Social workers noted that youth typically must simply fend for themselves, getting to school on their own (if they go) and getting to their own appointments. One social worker observed that most of the time, youth in group care do not even know the names of their counselors. Law guardians and social workers also focused on other aspects of service provision that they found to be particularly problematic: agencies' failures to determine the services that youth need at the time they enter foster care; delays in getting services in place; variable quality in services for youngsters who do not speak English; and services that are so mediocre that they are equivalent to receiving no services at all.

Specific services for youth in congregate care

Respondents primarily focused on two service areas as critical for youth in congregate care: education and mental health services. They also commented, although to a lesser degree, on physical health services, substance abuse treatment services, legal services, and youth development services.
Education

All groups of respondents expressed concerns about the lack of focus on education for youth in congregate care. One agency representative, for example, observed, “Education is the most neglected issue in foster care,” and went on to state:

“The typical kid arrives on our campus five plus years behind and we don’t talk about education at all—we do, but the system doesn’t. These kids are not going to graduate. We can give them a safe environment, connect them with their families, enrich their lives, etc., but in the end, they will be confined because of an inadequate education…Child welfare is a social work territory. Social workers’ primary competence is therapy and group and family work, not education. They tend to sit back and say that education is the education establishment’s problem.”

One social worker noted that ironically, children are removed from their parents’ custody when they are young because of educational neglect but when they are teens in foster care, their educational needs are not taken seriously. Another social worker stated, “one of the things I find so interesting and upsetting is that education is, really, for older kids, more than anything else, the lynchpin about where they’re going to go after foster care. You can look at the roads, and if a child is going to graduate high school, they’re going down one road most likely. If a child is not going to graduate high school, they’re going down another.”

Respondents identified a number of specific problems in the provision of educational services to youth in congregate care:

Lack of attention to basic educational needs. Both social workers and law guardians commented that despite the fact that many older youth (ages 15, 16, or 17) read at the second or third grade level and continue to fall behind educationally, their needs for basic educational services are not addressed.

Overuse of special education. Judges, social workers, law guardians, and organizational representatives expressed concerns about the inappropriate enrollment of youth in special education programs. One judge stated, “many agencies just throw everyone into special ed.” Law guardians and social workers noted that youth in RTCs are inevitably enrolled in on-site schools and placed in special education irrespective of whether they need special education services. One law guardian said that on-site special education settings are dedicated to management of behavior problems and not to education, and, as a result, bright youth who are placed in such settings have no chance to advance academically. One social worker said that for some youth, regular school is the one place they do well and feel good about themselves and, “if school is their saving grace, don’t take that from them.”

Absence from school for extended periods of time. Judges, law guardians and organizational representatives stated that while in congregate care – particularly in group homes – youth often miss school for long periods of time. One judge observed that youth in group homes are “out of school for months.” A law guardian noted that youth often miss from 2 weeks to 6 months of school and lose continuity in school when they enter care or change placements. Two organizational representatives stated that there is no effective system for transferring school records a situation that “often repeats itself in the life of a child.” Another organizational representative attributed the high dropout rate among children in foster care to the fact that they miss so much school.
Public schools’ resistance to enrolling youth in congregate care settings. Both law guardians and organizational representatives stated that public schools do not readily accept youth in congregate care. One law guardian reported that in some cases in which the community is primarily white, schools do not welcome black and Latino youth placed in group care facilities. One organizational representative observed that public schools are not eager to enroll children in foster care, particularly older children, because they view them as troubled and as not able to do well academically, thereby affecting schools’ ratings on test scores and attendance.

Lack of comprehensive education plans. Several social workers expressed concerns about the absence of meaningful educational planning for youth in congregate care. One social worker described the current placement process as “a defeatist system” in which there is not “a good match” between what youth can achieve and the programs in which they are enrolled. Another indicated that youth are overly encouraged to obtain a GED when they could successfully complete high school. Others focused on the inadequate educational planning upon discharge. One social worker stated that agencies do not always ensure that educational services (such as the services outlined in the youth’s Individual Education Plan) are in place when youth return home.

Problems regarding school transfers. Law guardians and organizational representatives commented on different problems regarding school transfers. One law guardian noted that although youth are to be maintained in their original schools, some youth in group care are transferred to schools at far distances (such as from the Bronx to Staten Island). One organizational representative commented that a 15-year-old is old enough to choose her own school and commute and that school may be the child’s only continuous community. "Kids say, ‘They’re taking me away. Those teachers are the only ones who know about me, who even know my name.’” Another organizational representative expressed concern that youth in care do not have opportunities to make the best possible transition from elementary to middle and from middle to high school (which involve an application and selection process in New York City). This organizational representative stated that things “go much worse for children and youth in foster care. There is no one to research good schools for them, ensure that they take the right tests and help them develop a portfolio so that they will be accepted by a good school. They are trapped in low-performing schools.”

Failure to promote youth’s educational involvement. Social workers and organizational representatives expressed concerns that congregate care staff do not play active roles in meeting youth’s educational needs. One social worker reported that youth are expected to be very self-reliant in group care, in particular, and that no one ensures that young people go to school or helps them with homework. An organizational representative observed that agencies that have staff assigned specifically to educational issues have much better outcomes, “but most agencies are run by assigning cases to caseworkers who are then overall responsible for the child or case. The momentary crises overtake long-term things like the importance of education.” Another organizational representative stated, “And, I think, there is an underlying belief that this is not going to matter anyway in this child’s life, so why push it?”

No educational role models. One organizational representative expressed concern that youth in congregate care do not have educational role models they can emulate:
“It’s not like they can say, ‘Well, look at Susie. She graduated high school and now she’s got a job.’ There’s, like, nobody. All you can do is say, ‘look at Susie, she was pregnant at 15, and she’s got this really cute 2-year-old, and she’s got somebody to love’.”

**Mental health services**

All groups of respondents expressed concerns about the availability and quality of mental health services for youth in congregate care and stated that the mental health needs of youth are under-addressed. Respondents raised a number of specific concerns about mental health services for youth, including:

- long waiting lists for services;
- an inadequate array of mental health services to meet the needs of youth;
- very limited treatment services at RTCs;
- lack of routine screening for mental health services;
- failure to routinely provide mental health services;
- poor quality of mental health services;
- no standards for the delivery of mental health services;
- failure to ensure confidentiality of mental health information; and
- inadequate funding for these services.

Many comments focused on the use of psychotropic medication, although perceptions varied as to both the extent to which psychotropic medication was being used and the appropriateness of its use. Agency representatives reported varying levels of psychotropic medication use in congregate care settings, with their estimates varying from 70% to 80% to less than 5% of the youth in congregate care. There also was variation in opinion regarding the appropriateness of the current level of use of psychotropic medications. One law guardian, for example stated, “some kids are over-medicated. They’re like zombies”; another stated that overmedication does not seem be “a pressing problem anymore”; and a third saw important differences among facilities: “Medication is a huge issue in some of these places where, rather than addressing individual therapy, it’s an issue of medication, managing behavior by medication, not teaching kids other alternatives and ways to cope with things, and it really should be both.” Among the specific concerns that law guardians raised in this area were: insufficient efforts to obtain second opinions regarding the prescribing of psychotropic drugs; the failure on the part of older psychiatrists to use new and improved psychotropic medications; the use of medication instead of behavior management techniques to help youth control their behaviors; and prescribing medication for youth who do not need it.

Social workers had different perceptions as to whether youth know what medications they were taking and why. One social worker stated, “I really am amazed how well kids understand why they are taking medication” and reported that psychiatric professionals do a good job informing youth about medications. Another social worker, however, stated that psychiatrists do not discuss with youth the reasons for prescribing medications.
Respondents frequently commented on the quality of the mental health professionals who serve youth placed in congregate care settings. Judges, law guardians, and social workers focused on the inadequate numbers of mental health professionals on congregate care facilities’ staff. One social worker stated that in some group homes, there is only one psychologist available for all the clients, and in many homes, therapy is done in a group setting, allowing staff to hear youth's comments about them. Social workers also expressed concerns about the conflict of interest that arises when caseworkers at RTCs provide therapy and the fact that many caseworkers who provide therapy lack Masters in Social Work (MSWs). Organizational representatives expressed concerns that there are too few mental health services providers in the community to meet youth's needs.

**Health care services**

Only a few respondents expressed concerns about general health care services for teens in congregate care, perhaps because, as one respondent stated, “Health services, I would probably say, is one of the highest functioning departments or areas of foster care. I would say kids probably get better care, better medical care, in foster care than they do out in their community environments or their neighborhood environments.” When concerns were mentioned, they typically centered on the absence of attention to birth control and other family planning services (some respondents expressed concerns about the lack of access to family planning information and the absence of assistance in terminating pregnancies even when the pregnancy resulted from rape when young women were placed at Catholic agencies); limited dental services; and teen mothers’ difficulties in navigating the Medicaid program for their children.

**Substance abuse services**

Only agency representatives focused on substance abuse treatment programs and their concerns were principally related to diminished funding for these services. One agency representative stated: “70% of our kids present with substance abuse” and reported “we're going to have to get some grants, I can't give up that program – it's too important for some of the kids. I don't know how we'll do that.”

**Legal services**

Agency representatives, judges, and organizational representatives stated that legal services needed to be improved for immigrant children and for children and youth in foster care in general. One organizational representative, for example, said, “There is no system for identifying young people who are undocumented. There is a complete lack of knowledge about the process [of applying for legal status for youth in foster care]. Nobody is talking about this at ACS.” An agency representative similarly commented, “ACS workers don't have a clue as to what the needs for obtaining permanent resident status are. Unless it is a person's specific interest, or the case is passing from one worker to another, I haven't found anyone in 5 years of working at my agency who was specifically knowledgeable about these issues.”

Organizational and agency representatives also expressed concerns about the current system of law guardian representation for youth in care. One organizational representative said that because of understaffing, law guardians are overloaded and lose contact with youth as the case “falls off a law guardian's radar screen” when there is no court action pending. An agency representative remarked that while some law guardians are “very knowledgeable about the case,” others are not because they are too young and inexperienced to understand the needs of the youth.
Youth development services

One judge stressed the need for congregate care facilities to develop a better understanding of “teen dynamics” and provide services that are developmentally appropriate. Organizational representatives also placed a focus on the need for more programs with a youth development focus – “a real commitment to youth development and that do more than just foster care and family services but also a lot of youth services.” Some organizational representatives emphasized the importance of addressing youth's developmental stages but believed “that is not happening now. The developmental programming just isn't there.” Some organizational representatives, however, stated that foster care agencies may not be the best provider of youth development services but, instead, should pay for these services or ensure that youth receive them.

SAFETY ISSUES IN CONGREGATE CARE

On the issue of the safety of youth in congregate care, respondents in all stakeholder groups:

- made observations about the extent to which safety is a problem;
- discussed specific safety issues in congregate care settings; and
- commented on the relationship between the quality of staffing and safety.

The extent to which safety is a problem

All respondents made observations about the extent to which safety is a problem in congregate care. Law guardians, social workers, and organizational representatives found safety to be an area of serious concern. One law guardian, for example, stated that young people do not feel that they are respected or treated well in group care and do not feel safe physically, and another said, “The children are not safe. They're not properly supervised. The people caring for them don't like them.” Judges expressed concerns that youth leave congregate care settings (thereby going AWOL) because of fears about their safety in those settings.

Agency representatives were split as to whether safety was an issue in congregate care. One group of agency representatives stated that safety was not an issue. These respondents indicated that youth in congregate care were no more unsafe than in the general community, and although they recognized that fighting may occur, they stated that it is more like “brothers and sisters fighting” and the “kids do not feel unsafe.” Another group of agency representatives, however, believed that safety was an issue, particularly in RTCs. Among the comments that agency representatives in this group made were:

“Even in the best RTCs, safety is neglected. It’s really challenging and a good way to keep kids safe from each other hasn’t been developed anywhere. The best advice is to teach kids their responsibilities, along with their rights.”

“It is scary to be at some RTCs. You feel the kids control the campus. I felt that way when I first took over this facility.”
Specific safety issues
Respondents identified a number of specific safety issues: peer-on-peer violence, stealing, inappropriate staff conduct, the poor physical conditions of congregate care facilities, and dangers to youth outside the facility.

Peer-on-peer violence
All respondent groups commented on the issue of peer-on-peer violence in congregate care facilities. The majority of respondents believed that it was a serious issue, the exception being some agency representatives who stated that peer-on-peer violence was not a problem. One agency representative, for example, reported a complete lack of awareness of any peer-on-peer violence, and another stated that peer-on-peer violence is “very, very rare.”

Other respondent groups (including many agency representatives), however, found peer-on-peer violence to be a serious issue. One judge stated, “being safe from other kids is something that has to be taken very, very seriously.” Law guardians and social workers expressed high levels of concern about this issue. Both law guardians and social workers reported that youth often are fearful of other youth and that gangs in facilities prey on other teens. Law guardians also indicated that certain youth – particularly GLBTQ youth – are highly susceptible to being victims of violence; violence is a particular issue when sex-offending teens are placed with the other youth; and girl-on-girl violence is of growing concern. Social workers also commented that residents intimidate others through sexual advances, and one social worker reported that weapons are brought into group homes with the result that “kids get cut. Arms get broken.” Organizational representatives likewise expressed concerns about peer-on-peer violence. One stated, “There is definitely the problem of fights, especially where they group kids of different ages and cultural groups in the same facility. One of my clients was beaten in his sleep.”

Stealing
Social workers, law guardians, and organizational representatives expressed concerns about the safety of youth's possessions in congregate care. Several social workers commented on how commonly youth's personal belonging are stolen in congregate care facilities, with one describing stealing as “routine” and another stating that it occurs “on a daily basis.” Law guardians made similar observations. One law guardian reported, “Things are always stolen, nothing is safe. Teens cannot trust that what they have will be there when they get back.” Social workers reported that their clients had clothing, money, and gift certificates stolen. Law guardians also described similar thefts and stated that an even bigger problem is that stolen items, such as clothes, are not readily replaced. One stated that it takes months for youth to obtain new clothes, and in some cases, important items such as sneakers or jackets are stolen and agencies refuse to replace them. An organizational representative voiced the same issue, reporting that “nobody does anything to replace [their stolen items], even in good homes. Their things mean so much to them particularly when they’ve moved from home to home.”
Inappropriate staff conduct

Although one agency representative stated, “Kids can make up stories about staff. [Violence] doesn’t happen very often,” a large number of other respondents expressed concerns about inappropriate and in some cases aggressive staff behavior. Law guardians and social workers reported the use of corporal punishment, the use of restraints, and the inappropriate use of isolation and deprivation. One social worker described instances of staff using physical force with youth, including an incident in which a staff member threw a youth to the ground, resulting in a rug burn on the child’s face. One law guardian stated, “[youth are] put in a room and tied to a chair…[These punishments] simply make it worse. It makes [youth] more angry and more hostile.” Organizational representatives also expressed concerns about the inappropriate use of isolation. One organizational representative reported, “We had a case where a young person who swore was sent to isolation.” This organizational representative reported poor record keeping regarding the use of isolation which kept the “higher ups” of the agency unaware of the actual day-to-day operations in this regard.

Social workers described a number of inappropriate behaviors on the part of staff toward residents. One social worker described bullying, particularly of children with behavior problems. Another discussed the situation of a client who was placed in care because his mother hit him with a belt who then was threatened with the same behavior by a RTC staff member. Another social worker recounted a situation in which a young person was strip-searched and subjected to an anal cavity check when he arrived at the RTC. Another described a client who went AWOL and then returned to the group home to obtain his clothes. Although the agency’s policy was to place an AWOL youth’s belongings in a trash bag in the office, the young person was not allowed to retrieve his clothes until the caseworker gave permission, an action that the youth viewed as a form of punishment.

The poor physical condition of congregate care facilities

Organizational representatives and social workers also commented on dangers to youth posed by the poor physical condition of many congregate care facilities. One organizational representative stated that because of inadequate funding for capital costs and repairs, group homes present dangers of physical harm to the youth who live there. Social workers also described health hazards at some congregate care facilities. One social worker shared a client’s description of a facility’s time-out room (where youth were expected to eat lunch as well) as dirty and as having four walls with no windows, pieces of food on the floor, and a urine smell. Another social worker described conditions at one mother-child facility where a client found a rat in her baby’s bed and had seen cockroaches in the cupboards and another where the daycare center was filthy.

Situations outside the facilities

Judges, agency representatives, and social workers expressed concerns about conditions outside congregate care facilities that put youth at risk of harm. One judge focused on the victimization of young women by older men, stating, “When I see young women in foster care who are pregnant by older men, I wonder how did these men get access to these children, where is the supervision?” Agency representatives had concerns about young women as well, but saw the difficulty as springing from the youth’s past experiences and the fact that congregate care facilities are not secure and youth can easily leave at will. One agency representative, for example, expressed concerns about young women placed in RTCs after having run
away or gone AWOL from other foster care placements, and who have learned to parlay their sexuality in exchange for someone's care. Noting that RTCs are not secure facilities, the respondent stated that agencies cannot adequately protect young women who are putting their lives and health at risk.

Social workers described safety concerns related to the neighborhoods in which group homes are situated. They reported that people in the community are able to gain entry to residences and that there is sometimes a threat from the outside community because the campus is open and supervision is not sufficient. One social worker expressed particular safety concerns for transgender youth. This social worker reported that this group of youth commonly prostitute to obtain money for street hormones (for which they cannot currently get a prescription), and as a result, they place themselves in danger, and they face threats to their safety from neighborhood residents.

Judges also raised questions about the safety of youth on AWOL and expressed frustrations in obtaining assistance to find the youth and ensure their safety. One judge stated, “Another thing is AWOLing, trying to get cooperation from the city police department is maddening. I repeatedly have to issue orders to the commanding officers of the precincts to give me a written account of what steps have been taken to locate missing children…They don't know where these kids are, what is happening to them.”

**Importance of staffing with regard to achieving safety**

Agency representatives, social workers, law guardians, and organizational representatives shared the belief that the safety of congregate care facilities is tied to having a sufficient number of adequately trained staff. Agency representatives identified several staffing and program elements that they believed were essential to ensuring safety: staff who make personal connections with youth, room searches, fifteen-minute checks (head counts), roving vans 24 hours a day on campus and in the community, and staff who are familiar with police operations and counseling. Agency representatives were concerned that as a result of budget reductions, their ability to hire sufficient numbers of qualified staff may be undercut, but one agency representative stated, “It's not just a matter of funding, but passion, vision, and values that drive safety policies.”

Law guardians, social workers, and organizational representatives attributed safety problems to several staffing issues: the hiring of staff who do not like adolescents, lack of staff training, staff turnover, and an inadequate number of staff to monitor residents. Organizational representatives emphasized that staff often lack skills (because of inadequate training and supervision) to maintain control, and as a result, they resort to physical restraint, threats, or calling the police for any outbreak “even if it’s a scuffle between two people where nobody really got hurt.” Social workers expressed concerns that staff simply stand by, failing to intervene to de-escalate the situation, when serious fighting between residents occurs. One social worker commented that in some cases, staff may even instigate the residents' violent behavior.
PERMANENCY FOR YOUTH IN CONGREGATE CARE

Respondents commented on a range of issues related to achieving permanency for youth in congregate care:

- the overall quality of efforts to achieve permanency for youth in congregate care;
- the extent to which reunification is considered, supported and achieved for youth;
- the extent to which youth’s connections with extended family and other adults are supported;
- the role of adoption as a permanency option; and
- the use of independent living as a permanency goal for youth in congregate care.

The overall quality of efforts to achieve permanency for youth in congregate care

All respondent groups commented on the quality of efforts to achieve permanency for youth in congregate care, but their perspectives were quite varied. Organizational representatives stated that negative assumptions undermine a commitment to achieving permanency for youth. One organizational representative, for example, stated that negative stereotypes of adolescents in general — “the raging hormones, that they are out of control” — and of black males, in particular, undercut serious efforts at achieving permanency. Another said that there is a general belief that a focus on permanency does not “work” for teens – particularly teens in congregate care – and commented, “if you don’t believe it, you can’t do it, especially when it comes to adolescents.” This individual also stated, “just because you are in congregate care doesn’t mean that you don’t need a permanent family connection. That’s how the system has worked, though. When kids are put into a congregate care setting, the social workers stop working on permanent family connections. We’re not working on a family.” This individual further observed that many young people lack confidence about having a family or family connections and that professionals translate youth’s uncertainty into the conclusion, “he or she doesn’t want the whole thing, so forget it.” In a similar vein, another focused on the importance of maintaining an open mind when working with youth around issues of permanency, stating:

“Every day keeps reminding me that every day you have to hold your assumptions lightly. What young people want you can’t assume.”

Organizational representatives identified a number of specific issues that they believed worked against achieving permanency for youth in congregate care:

- System fragmentation. One organizational representative said, “people who work with the same kids don’t talk to one another,” often because congregate care programs are located “up the river” (that is, outside of New York City) and do not have relationships with partners in communities where families live. “It really hurts the planning for youth.”

- A focus on operational issues and not permanency. One organizational representative, for example, observed that congregate care facilities are primarily concerned with managing behaviors, the cottages, and other matters and “they lose the life picture.”
• Fiscal incentives that do not recognize the individual needs of youth. An organizational representative stated, “I don’t think that the money supports real permanency outcomes for adolescents. I think it’s sort of a one-size-fits-all kind of approach to child welfare financing, and that’s as true in New York State as it is in the country as a whole.”

A number of law guardians and social workers expressed serious concerns about the quality of permanency planning for youth in congregate care. One law guardian, for example, stated, “It’s always a big fight, it’s never focused on the child, NEVER.” Another stated that “permanency planning for teens is not successful at all. They are not going anywhere.” Yet another law guardian stated that permanency planning is “a self-defeating process” – there is little focus on work with the family, the youth remains in care for a long period of time, the young person becomes bitter and refuses to consider adoption, and little effort is made to find an adoptive family for him or her. Social workers also expressed concerns about the absence of work with families unless they live close to the facility and the failure to consider adoption for youth once they reach 15 or 16 years of age. One social worker expressed concern that family resources are not considered. This social worker gave as an example the case of a youth who entered congregate care having strong connections with an aunt – talking with her on the phone, visiting her, and expressing a desire to live with her – and no one explored the aunt as a possible resource for the child.

Judges focused on the impact of the type of placement on the achievement of permanency for youth in congregate care. Their views, however, differed as to the type of placement that supported the best permanency outcomes for youth. One judge stated that youth placed with foster families are more likely to achieve permanency because there is a greater chance of reunification and foster parents often become adoptive parents. Another stated that RTCs and foster homes do a better job with regard to permanency than group homes because youth in group homes have more serious problems and receive fewer services and there are fewer professional staff at group homes. Another judge, however, stated there was no difference between RTCs and group homes in terms of achieving permanency.

Agency representatives were not in complete agreement regarding whether permanency planning should even be a part of the work that congregate care facilities undertake with youth. Although the majority of agency representatives believed that permanency was a key focus for them, one agency representative stated, “RTC kids have very serious behavioral issues; it’s an unusual family that can handle that, even when it’s their own child,” and further observed that “RTC’s are about helping youth function and be able to handle relationships with adults, but they really aren’t about permanency at all.” Agency representatives who endorsed permanency planning as a key congregate care function had different views regarding the extent to which permanency was being achieved for youth in congregate care. Some expressed concerns about the lack of resources available to support adequate permanency efforts, but others believed that permanency was being achieved successfully. One agency representative said, “the agency does ‘pretty well’ in terms of having a plan for the child. They make sure that the plan is set early, at around 13 or 14 years of age, not 16 or 17…kids staying in an environment/placement for years helps the permanency goals succeed.” Another, however, expressed concerns about the success of permanency planning efforts, stating, “the worst kids here, behaviorally, are those who have no discharge resources…I think that they are the worst kids because they have no discharge resources.” This respondent further stated, “institutions create kids who know how to live in institutions, not in families. It’s a problem.”
Reunification

Although agency representatives commented only minimally on reunification as a permanency option for youth in congregate care, other respondent groups discussed this issue in depth. Judges, social workers, and organizational representatives (and to a lesser extent, law guardians) placed emphasis on work with families when youth enter foster care and the need to strengthen youth’s connections with their families. These respondents expressed concerns that agencies do not work effectively with parents. One judge said that because there is high caseworker turnover at agencies, relationships are not effectively built with parents. This judge also commented that the extent to which agencies work with parents often depends on the parent: “If the parent wants to be involved, the agency will help. If the parent is a pain, the parent won’t get help from the agency.” Another judge pointed to the irony of having goals for youth other than reunification and the fact that many youth who leave congregate care at 18 return home – a situation also described by social workers, law guardians, and organizational representatives. This judge stated that “this is an irony that is brought home to me daily. After all of this elaborate mechanism of removal, adjudication, placement, it think a lot of the kids end up going back home. Even the kids whose goal is independent living.” This judge reported instances of parents returning to court to vacate an order terminating parental rights based on the fact that the teen has been living at home. Similarly, an organizational representative observed:

“The way families are drawn together against all odds whatever the circumstances I think is exemplified by just how many kids do we see aging out of the foster care system and where do they go? They go home…even kids whose parents’ rights have been terminated…The bonds that hold families together are powerful, and often the system works to strain or shatter or destroy them rather than build on them.”

Social workers and organizational representatives attributed the lack of family work in congregate care to placements of youth in facilities outside their own communities (outside of New York City, and in some cases, outside New York State) and to the fact that parents often cannot afford the costs involved in traveling to visit their children. Both groups of respondents emphasized the importance of family visits in relation to reunification efforts, but both stated that visits often do not take place. Social workers stated that transportation, childcare for other children in the home, and distance create barriers for families. Organizational representatives stated that typical visitation plans are too limited, falling far short of what adolescents want in terms of visits with their families, and family visits are sometimes withheld as punishment. One organizational representative observed, “If you want family connections, you can’t do this.” One social worker stated that it would “make all the difference in the world” if an RTC were to make a commitment to the parent, accommodate the parent, act as if the agency really cared about that family, and worked within the parent’s personal constraints “because the child will leave the RTC and will go back into the family. They will.” Another social worker stated, “children should be returned to a home that is stronger than the one you took them from. The system really needs to work on that.”

In connection with visits, one social worker focused on the need for greater attention to sibling connections. This social worker stated that siblings are expected “to get from place to place for the visits and very often it does not happen.” This respondent gave as an example: a 10-year-old in a foster home and a sister, age 16, who had to get a court order to set up a time and place for their visits because they could not rely on case workers to help them arrange visits. The social worker commented, “the 16-year-old travels one hour and
45 minutes to see her brother because she knows that the visits are important for him. He has no one else in the world.”

Social workers and organizational representatives identified two additional barriers to reunification for youth in congregate care and their families. First, they pointed to the belief that family is not important to teens. One organizational representative, for example, stated that the message to youth is that “your value as a human being will only increase to the extent that you divorce yourself from your roots, that you reject where you come from, and I think that's psychically very damaging.” Another stated, “Not so many kids have nobody – it's not like they are all orphans. But we tend to look at them like they are orphans and ‘they are dropped from another planet’ and nobody knows who they are or who their parents were and that's just not real.” In this connection, several organizational representatives noted that agencies do not recognize or build on family strengths. Second, social workers and organizational representatives noted that inadequate attention has been given to racial and cultural issues. Social workers, in particular, emphasized the importance of training staff on cultural sensitivity so that they are aware of their own preconceptions and do not inject them into the decision making regarding reunification. One social worker focused on the fact that different communities have different definitions of family (specifically black and Latino communities) and stated, “I don't think there is enough recognition of that within the agencies to support kids reuniting with their ‘families’.”

**Connections with extended family and other adults**

Social workers, law guardians and agency representatives commented on efforts to develop connections between youth and extended family members and other adults. Social workers and law guardians expressed concerns that there is too little exploration of relatives' homes or possible connections with unrelated adults. One social worker said:

“The agencies are not as open to other types of family systems, for example, if a friend of the family that the child might have been really close to, who they have known their whole life and who they consider to be a kinship relative to…do a home visit [with] them, I don't think the agencies are as open to doing that.”

Agency representatives were somewhat divided as to the wisdom of pursuing such connections. One agency representative stated that it is “very hard to find people to take acting-out teens,” and told the story of a boy and his two younger brothers who had been freed for adoption, and for whom the adoptive placement disrupted. The agency prepared the older boy for a placement with teachers who knew him. Although extensive preparations were made, the placement fell apart when the teachers completely abandoned the boy and did not “even say good-bye to the boy.” Another agency representative, however, stated that “I think that is just good casework practice. When a kid comes in, you begin planning discharge…to whom? It doesn't have to be the family – it could be to a friend.”

**Adoption as a permanency option**

Respondents were deeply divided regarding the appropriateness of adoption as a permanency goal for youth in congregate care. Within each group of stakeholders, respondents expressed both concerns about the use of adoption as a permanency goal for youth and favorable views of adoption.
Concerns about the appropriateness of adoption for youth in congregate care
Agency representatives, as a group, were particularly concerned about the use of adoption as a permanency goal for youth in congregate care. A number of agency representatives objected to pursuing adoption for youth in congregate care. Among their comments were the following:

“Some teens feel that if their rights are terminated, if they’re adopted, then they are betraying their parents, even if they were abused and neglected. They don’t want to cut those ties. If the kids do want to cut those ties, the agency wants the decision to be theirs to make, not someone else’s. Some kids will choose to go back to their parents, regardless of their situation. Any kid that understands what terminating their [parents’] rights means doesn’t want to go through that stage.”

“Youth in congregate care often choose not be adopted because it is a hard concept for them to think about adoption since they have families. Their families may not be able to provide support for these youth and may not be equipped to deal with challenges these youth may face, but the youth still want them to be their families.”

One judge likewise expressed concerns about pursuing adoption for youth in congregate care, observing, “it is hard for these children to be in pre-adoptive homes after they have been in group homes.”

Similarly, some law guardians and social workers questioned the appropriateness of adoption as a permanency option for youth in congregate care. One law guardian, for example, stated, “Many of our clients do not want to be adopted,” and one social worker said, “adoption is not the answer for teenagers!” Other law guardians’ and social workers’ objections focused more on the limited number of adoptive family resources for youth. One law guardian stated, “For adoption, I think it’s very hard or impossible to find a home for anyone over the age of 14. It’s not practical.” Similarly, one social worker expressed concerns about the growing number of youth now free for adoption who simply “won’t be adopted.”

Positive views of adoption as an option for youth in congregate care
Only a limited number of agency representatives and law guardians expressed support for adoption as an option for youth in congregate care. One agency representative in this group stated:

“More work could be done to get kids adopted. 14 or 15 year olds often say they don’t want to be adopted and no one brings this up with them again. This should be something that is revisited when they are 17-19, when they know what they want. Much of their reluctance to saying they’d like to be adopted is that they are fearful that the adoption won’t work out.”

One law guardian expressed concern that many agencies give up on adoption for youth once they reach the age of 13 or 14 in the belief that no one will want to adopt the child. “That’s not true. We have some great potential parents that come forward.”
Social workers who believed that adoption was a viable option for youth in congregate care stated that agencies are not doing a good job in finding adoptive families for youth. One said that there is a “blanket practice that teenagers are not suitable for foster homes and are not suitable for adoption – that no one would be interested in doing this” and commented that youth are damaged by this message. Another stated that agencies simply stop looking for adoptive families for teens. “It’s the culture of the system, fourteen and up you’re not going to get adopted.” Among the comments made by judges who expressed support for adoption was the following: “My first preference for all kids, no matter how old they are, is adoption… even an 18-year-old can be adopted.”

One organizational representative who expressed support for adoption as an option for youth in congregate care stated that the key barrier is the belief that no adoptive family would want a teen in foster care. This organizational representative stated that if anyone expresses interest in adopting an adolescent, the person is seen as having an ulterior motive, and the suspicion is even greater when the adolescent has made a connection with the adult. This respondent stated that working with youth toward permanency requires small steps, such as the young person and the family first getting to know one another as the individuals move the process slowly in the direction of adoption. The respondent stated that youth often already have adult resources in their lives and gave the following example:

A Latino young man, age 18, in a group home told the staff that he did not want to be in a group home. He was told that there were no homes for him. In a meeting with the boy, it was learned that (1) his grandfather (who happened to be a social worker) had started to communicate with him; (2) a friend of his mother whom he had known for years had been calling and sending him cards; and (3) his younger brother’s adoptive mother had offered him a bed in her home whenever he wanted to come to visit. “The agency didn’t have resources for this boy, but the boy had resources. All the agency needed to do was work with him to convert those resources into long term resources.”

**The use of independent living as a permanency goal for youth in congregate care**

Respondents’ comments on the use of independent living as a permanency goal for youth in congregate care typically centered on the policy issued by the Administration for Children’s Services, effective July 1, 2003, that limits the use of this option as a goal. Under the new policy, no youth in foster care under the age of 15 can be assigned a permanency goal of independent living without the prior written permission of the ACS Deputy Commissioner or his/her designee and without a written concurrent family-based plan for reunification, discharge to relatives, adoption, guardianship, or legal custody. A similar requirement applies when youth are 16 or older but approval is to be given by an ACS case management supervisor or field office child protective manager. Typically, those respondents who questioned the wisdom of adoption as a permanency option for youth in congregate care supported independent living as a permanency goal and took issue with the new ACS policy. Respondents who supported adoption as an option for youth typically expressed support for the new ACS policy.
Objections to limitations on the use of independent living as a permanency goal

Agency representatives, as a group, expressed concerns about the ACS policy limiting the use of independent living as a permanency goal. Some agency representatives appeared to believe that the goal of independent living had been eliminated altogether and made statements such as the following:

“It is unrealistic to eliminate the independent living goal. There are youth who are not returning home, do not have adult resources, and financial/personal resources are not being invested to help the youth find people to support the youth. If it’s eliminated, it will only be on paper. Ultimately, the youth will have an 03 goal [the number used to refer to independent living] and nowhere to go to, or an 04 goal [adoption] and realistically nowhere to go.”

One agency representative stated that ACS’ new independent living policy could result in the “cutting of independent living funding since kids are supposed to be being placed elsewhere.” This respondent approved of the philosophy behind the new independent living policy, but said, “It’s the practicalities of the costs of [the] translation [of the policy] into reality [that] I’m worried about.”

Some law guardians, social workers and judges expressed concerns about limitations on the use of independent living as a permanency goal. One law guardian, for example, stated that independent living was an appropriate goal because youth in congregate care do not return home and there are not adoptive resources for these youth. Another law guardian said, “The new policy [limiting the use of independent living as a permanency goal and requiring a concurrent family-based plan for youth with that goal] is not well thought out. It defies logic.” One social worker stated, “ACS does not accept a goal of independent living for younger kids, but they should because for some younger kids it is just what they need.” This social worker gave as an example a girl who was placed in a diagnostic center when very young and not moved for years. She stated at the beginning of her placement that she wished to be adopted but when it was decided that an adoptive family would be found for her, she said she wanted to live in a group home because she was accustomed to institutional living at that point. One judge similarly noted that independent living is an appropriate goal for youth because of their experiences in congregate care.

Support for the policy limiting the use of independent living as a permanency goal

Some respondents, however, agreed with limitations on the use of independent living as a permanency goal. Judges, as a group, took this position. One judge stated that the ACS initiative “really recognizes that children really need the continuing relationship with a caring adult, and it only takes one.” This judge stated that congregate care does not usually provide “for one-to-one care by someone interested specifically in their progress, and who will be there for them to come back to.” Another judge stated that independent living provides good tools for youth but “shouldn’t be the plan.” Another reported not being “a fan of independent living as a general rule; it has been a dumping ground when we don’t know what else to do with a kid.” Another objected to the use of independent living as a permanency goal as “a default because of the age of the child,” and stated that this practice “needs to be rectified.”
Some social workers also expressed concerns about the use of independent living as a permanency goal. One stated that independent living becomes the goal for youth because agencies fail to explore resources for them. Another observed in connection with the frequent use of independent living as a permanency goal that group homes are “set up as an excuse to keep the kids in the foster care system without permanency.”

YOUTH INVOLVEMENT

Respondents were asked about the extent to which youth in congregate care are involved in planning and making decisions about their current situations and their futures. Respondents commented on:

• The degree to which youth are involved in decisions that affect them personally;
• The factors that affect the extent to which youth are involved in planning and decision-making;
• The extent to which youth participate meaningfully in Service Plan Reviews (SPRs); and
• Youth participation in court proceedings

Youth involvement in planning and decision making

Respondents expressed a variety of perspectives on the issue of youth involvement in planning and decision-making. Some agency representatives and one judge stated that youth have adequate opportunities to participate in crucial decisions about their lives. One agency representative stated, “I can’t think of any plan that’s ever been made for a teen without the teen being involved in the discussion.” The judge reported that youth often are involved in planning and decision-making, not only when there are problems but also when things are going well. Some respondents, however, stated that the degree of youth involvement depends on the interest and motivation of the youth. Agency representatives stated, “It depends on the adolescent – their degree of interest, whether or not they feel empowered, whether or not they want to participate,” and “kids are involved depending on the kid – they are given the opportunity.” Similarly, one law guardian reported that youth are “probably involved in their own decision making,” but that the level of involvement depends on the young person.

A larger number of respondents stated that youth are not appropriately involved in planning and decision-making on matters that affect them directly. Organizational representatives expressed the belief that although youth should be actively involved in making decisions and planning for themselves, they are not. One organizational representative stated that systems “need to work with the youth rather than to the youth and... youth should be part of planning their lives and setting their goals, just like youth who are not in foster care” but stated that this goal is not being achieved. Some agency representatives, as well as law guardians and social workers, stated that many decisions are made in which teens have no say (such as where they will be placed) and that youth are involved only minimally when they are allowed to play a role in planning and decision-making. One law guardian, for example, said that when youth in congregate care speak up, staff often tell them that they cannot have what they want because they have not demonstrated that they deserve what they are requesting.

Social workers and judges commented that agencies are not comfortable with youth involvement. One
social worker said that agencies are threatened by teens who advocate for themselves. One judge stated that caseworkers often have an adversarial relationship with older children in care because “youth want to have a say, and caseworkers are not accustomed to it.” This judge observed that caseworkers often characterize youth as having conduct disorders and use that rationale for not listening to young people.

Factors affecting youth involvement
Respondents identified several factors that they believed affected the level of youth involvement in planning and decision-making. One agency representative stated that a factor that supports youth involvement is a “strength-based youth development” model that asks such questions as “What are this youth’s strengths? How has this youth been able to cope? What has this youth been able to achieve despite enormous obstacles?” Other respondents identified factors that negatively impact youth involvement. One organizational representative stated, “I think a lot of the programs and policies in foster care are about changing the systems around them and they don’t see the teenagers themselves as a source of power and strength and action.” Another organizational representative attributed the lack of youth involvement to the perception of many teens that they are being scrutinized by the agencies to which their cases are assigned. “There’s often an assumption…that if there is a problem with the teen in a family then the teen is the cause of the problem… If the young person was 12, the parents would be blamed. But, if the young person is 16, then the young person is blamed.”

Law guardians and social workers stated that youth do not become involved in planning for themselves because they do not believe that agencies will actually listen to them. One law guardian commented, “the general attitude is that teens don’t know what they want. That’s not true.” Both law guardians and social workers stated that youth are asked for their opinions, but they are not really heard – youth say what they want but the agencies do not take steps to help youth achieve their stated goals. As an example, one law guardian shared the situation of a youth with anger problems who came into care because of neglect. He repeatedly asked to be moved from his RTC placement to a group home. ACS refused, and the court declined to intervene, believing such an action to be “micro-managing” ACS. The law guardian stated that since these developments, “the teen has broken someone’s jaw, and ACS is saying, ‘see we told you so’.”

Youth participation in Service Plan Reviews
Respondents had varying views on the degree of youth involvement in Service Plan Reviews (SPRs). Some social workers and agency representatives stated that there has been significant improvement in the level of youth involvement in SPRs. One social worker, for example, stated, “More than before, kids are invited to SPRs. They are not always listened to, but it is better.” An agency representative stated, “[ACS] is gradually moving into family conferencing so that child, family, and relevant adults can work out plans and programs. That’s an area in which we are doing better.”

Other respondents, however, expressed less optimism about the level of youth involvement in SPRs. One law guardian stated that caseworkers do not ask youth if there is someone whom they would like to invite to their SPRs nor do they help youth identify possible participants. This law guardian reported that youth do not feel that they are meaningful participants in SPRs, they believe that they are simply “going through the motions,” and they often feel intimidated by these reviews. One social worker stated that youth sometimes participate in SPRs, but ultimately, the youth’s position prevails only if it is the same as the position of the foster care agency social worker. One social worker commented:
“I think it’s important to have [youth] included in their own SPRs, but for what purpose if we are not really listening to what they’re saying or if we’re not addressing the needs that they’re bringing to the table? And if they felt like they were being heard and they felt like their needs were being met, they may be more willing to think of suggestions that are being made to them.”

Youth Participation in Court Proceedings

Judges focused on youth participation in court proceedings. Two judges reported that the voices of young people are not heard enough. One judge stated, “I’d like to hear more from the child,” and another said, “you have to make sure the kids come in.” One judge stated that typically, youth do not participate because of transportation and time constraints, but noted that youth participation is “worth it.” Stating that “autonomy is a big issue,” this judge stated that being heard in court would likely “reduce AWOLing, premature discharge from foster care, and inadequate planning. I’m not saying it always makes a difference or is the only way. Just that it can. Sometimes kids come to court and they say that what the caseworker is expressing as the child’s views is not what they said.” Another judge expressed concern that youth’s voices are presented in a very formulaic way, such as in statements that “my client does or does not want to go home.” This judge objected to youth’s actual presence in the courtroom because “in court, everyone is talking about what mom or dad did or did not do. It’s a horrible message to send to kids that mom or dad is bad” and proposed, instead, communication with youth through letters or audiotapes.

TRANSITIONING FROM CARE

Respondents were asked about the preparation of youth for discharge from care, particularly youth with the goal of independent living. Their comments focused on two areas:

- The overall quality of preparation for independent living; and
- Outcomes for youth who leave foster care (in the areas of health care, housing, education, employment, personal connections, access to needed papers, and immigration/legal status).

The quality of preparation for independent living

Respondents were asked about the extent to which youth in congregate care are adequately prepared to leave foster care and live on their own. Only agency representatives gave independent living programs good marks. A number of these respondents indicated that independent living programs adequately prepare youth for life on their own. Some agency representatives, however, reported that youth vary in terms of their level of preparation. One agency representative said that 55% to 60% of youth are ready for independent living, “40% of teens are slow starters” and may need to re-enter care after trying independent living, and another 5% “live out the negative stuff, like going to jail.” Some agency representatives focused on the need to strengthen aftercare services for youth as a “critical” area needing attention.

Only among agency representatives were comments made that the lack of success of independent living preparation is attributable to the youth themselves. One agency representative said that some youth have “no motivation” to graduate from school or get a job. Another expressed frustration with the task of teaching teens how to live independently when they lack the desire to learn such skills: “[E]ven if you are able to
teach, how does one hold youngsters accountable when they are not willing?” One agency representative also attributed deficits in independent living preparation to ACS rules and regulations. This respondent said,

“[ACS] policies and procedures are developed to protect the youngsters…Issues such as safety take precedence over giving youth opportunities to be independent.”

Judges, law guardians, social workers, and organizational representatives expressed significantly more negative assessments of current efforts to prepare youth in congregate care for independent living, and they were more likely to attribute the weaknesses in these programs to programmatic issues rather than to the youth or to ACS. One judge stated,

“[Independent living programs] do not tend to foster self-sufficiency, to encourage children to build on their individual skills and talents. It does not play to the child's individual strengths, but instead, it funnels kids to public assistance and Section 8 [housing].”

Law guardians and social workers likewise expressed concerns that youth receive only limited preparation for independent living and then are expected to manage completely on their own. One social worker, for example, observed that teens with a goal of independent living are not prepared to live in the community after they leave care – “no way.” Organizational representatives expressed similar views, saying:

“There is not a lot of understanding about the kids' real range of needs. If you are actually trying to create independence, what does that look like?”

“Some of these kids don't know what it's supposed to be like for them once they age out so they expect the real world to mirror what group home life is like.”

Social workers and organizational representatives stated that classroom instruction is insufficient to prepare youth for life on their own. One social worker reported teens' descriptions of independent living workshops as covering the same five or so topics that are repeated again and again. One organizational representative stated, “You cannot teach a kid to balance a budget in the abstract. Classroom-based training for independent living does not work.” Social workers stated that more focus is needed on “living in the world” with opportunities for the young person to “practice” for adult life in the community. One social worker stated that youth need role models or mentors to show them what they need to be doing to prepare for the transition.

Social workers, along with some agency representatives, highlighted SILPs (Supervised Independent Living Programs which provide youth with their own apartments under some level of adult supervision) as a key component in preparing youth for independent living. One social worker, for example, said that SILPs “have been really, really great in making that transition easier. We can supervise, but they learn to do things on their own.” Social workers and agency representatives, however, also commented on limitations on SILPs. Social workers said that SILPs are effective for only certain types of youth, particularly young people who are highly functioning and very good students. Agency representatives focused on the limited resources
available for these programs.

Both social workers and organizational representatives stated that the concept of independent living for youth aging out of foster care at the age of 18 or 21 is unrealistic. One social worker stated that it should not be “assume[d] that an 18-year-old, either in foster care or not, is going to be ready to go out and get their own apartment, get a job, live on their own and support themselves.” An organizational representative stated:

“Even if you are very adaptable, which most people aren’t, and you start to do really well in the congregate care facility, there is still this day when you are not going to live there anymore. The decision to leave home is hard even in a family but here you have a situation where there isn’t a lot of personalized care or individual planning – you are asking these kids to decide to be discharged at 18 or 21 with no one to go back to.”

Another organizational representative criticized the current approach to independent living as failing to take into account the demands on poorly prepared youth when they exit foster care. Yet another pointed to the poor quality of aftercare services provided by congregate care facilities, the absence of accountability for what happens to youth after they leave foster care, and the failure to develop concrete plans with youth that provide a “viable plan for survival.” These respondents, as discussed earlier, endorsed the permanency options of reunification, adoption, and connections with relatives and other caring adults as the more appropriate plans for youth in congregate care.

**Outcomes for youth who age out of foster care**
Respondents made a number of observations regarding outcomes for youth who have aged out of foster care. They commented on:

- Young people’s access to health care services;
- Housing for youth who age out of care;
- Educational outcomes;
- Employment outcomes;
- Personal connections after youth leave care;
- Access to needed papers; and
- Immigration/legal status.

**Health care**
Respondents had different perspectives on young adults’ access to health care after they leave foster care. Agency representatives reported that teens have at least “some” access to health care. One agency representative stated that health care is made a part of the discharge conferences for youth at the respondent’s agency, and one judge reported not approving independent living discharges unless youth have health insurance. Other agency representatives reported that youth are able to access health care when they work and have insurance through their jobs or they can obtain insurance through Medicaid. Law guardians and organizational representatives, however, expressed concerns about youth’s attempts to rely on Medicaid as
their health insurance program. One law guardian stated that most teens discharged from care are usually unable to obtain health insurance and that only the “more together” youth are able to negotiate the Medicaid process. Another law guardian stated that most youth leave care without health insurance because of timing issues — youth cannot initiate Medicaid or public assistance benefits until after they leave foster care — a “really tricky” situation. Organizational representatives similarly reported that there is no “smooth rollover of Medicaid” when youth leave care. One respondent noted, “The biggest problem I think young people face going into care is that they are totally disconnected from the health care system. Nobody knows them, so you suddenly get discharged, and nobody knows who you are. And so you just drift.”

**Housing**

All respondent groups commented on housing resources for youth who age out of foster care. Among the groups, only agency representatives stated that housing resources were adequate for youth (although many agency representatives thought otherwise, as discussed later). One agency representative in this group stated, “most youth have appropriate…living situations when they leave” care, and another reported not “[hearing] of too many of our kids who end up in shelters.”

Most respondents, however, expressed concerns about the adequacy of housing for youth who age out of care. Several judges commented that youth often are not discharged to specific addresses. One judge reported having cases in which the youth aging out of care had no place to live. The judge stated, “The law guardian comes in and requests that the kid remain in care because they don't have a place to go. So I stall, threaten, and control. And if I’ve seen it several times, it has to be fairly common.” Other judges also reported that youth are not discharged to a specific address. One stated, “We get an extension of placement petition. If the child does not agree to stay in foster care, the placement just ends, and she lives wherever she lives, with a boyfriend or whatever. The specific address is generally not the destination. Because it is fluid.” Another judge reported “a high prevalence, an unacceptably high prevalence of homelessness” among youth aging out of foster care.

Social workers expressed similar concerns that many youth who leave care “end up homeless.” One social worker observed, “housing for those who age out is terrible! Finding NYC housing is so terrible for anyone, especially these kids. How can a teen get it all together, pay rent, and everything else?” Another social worker illustrated the problem with the story of a young mother who had a job but could not obtain housing. The social worker stated, “this young lady is going to lose [her child] because she doesn't have housing. She is going to be punished because she doesn't have housing. This is the number one problem – adequate housing.” Organizational representatives expressed the same concerns. One noted, “The thing that's more difficult here is the housing issue. I mean it is impossible to find affordable housing in NYC. It's unimaginable that you could be 20-21 years old and be able to find a place to live in the City.”

Respondents also commented on the Section 8 housing voucher program. Some respondents had favorable views of the program. One agency representative reported, “The kids are now eligible for Section 8 housing. ACS [gave them that] a couple of years ago. They can [go] right [to] the front of the line for it now, and that's been great. The kids are really happy about it, too.” Some law guardians stated that the Section 8 voucher program has had an impact on housing availability for youth who age out of foster care, with more youth being discharged to a specific address.
Others respondents, however, believed that the program is not working as well as would be hoped. One concern was that because there is heavy competition for Section 8 housing, youth with housing vouchers cannot actually utilize them. One judge, for example, stated that landlords often prefer to rent to potential tenants “who show up with cash” and not a Section 8 voucher. A law guardian concluded that although Section 8 housing is the most common housing option for teens after they leave care, only a small percentage of youth obtain housing through the program. The law guardian observed, “the rest are on the streets, in prison, or with family.”

Social workers and organizational representatives identified additional concerns about the Section 8 housing voucher program. Social workers stated that caseworkers remain uninformed about Section 8 housing and do not give youth correct information. One social worker related the story of a 19-year-old who wanted to leave care with her baby, go to a shelter, and apply for Section 8 housing. The caseworker incorrectly told her that she could not apply until she was 21 (a youth can apply at age 18). The social worker observed, “[The caseworkers] don’t know what the services are.” Organizational representatives stated that problems arise because planning does not occur in a timely way. One organizational representative observed:

“I think there are tons of kids who don’t get any discharge planning until three days before they turn 21. That includes no application for a Section 8 voucher. If there is somebody who is putting in those applications, they are not done correctly.”

Education
Respondents addressed two aspects of educational outcomes for youth who age out of care: the extent to which they have graduated high school or achieved a GED when they leave care; and the extent to which they attend college.

Respondents expressed a range of concerns about the educational outcomes for youth who leave care. Social workers and judges made a number of observations regarding the extent to which youth in congregate care graduate high school or achieve a GED. Although one judge believed that most youth obtain a high school diploma or a GED, social workers expressed concern that because many youth in foster care lack basic reading skills, they are not likely to accomplish either goal. One social worker related the story of a boy who wanted to achieve academically but was functionally illiterate. The boy’s group home stated that he had not attended the classes that were offered, but the youth was not able to read even the information that the agency distributed on the classes. The social worker observed that without attention to the youth’s needs, it was unrealistic to expect that he would be able to complete school or be able to even complete a job application. One judge expressed concern that far more youth have GED service plans than high school diplomas, observing that GED programs are less “communal” and offer a different experience for youth than being part of a high school community.

Respondents had different views regarding the college attendance of youth who leave congregate care. A few respondents reported that many youth go on to attend college. One law guardian, for example, commented, “A lot of my clients are college-bound and are juggling getting financial aid and taking care of themselves and going to college,” and one judge reported that more youth go on to college than might be expected. This judge stated, “one of the best things ACS does is help children go to college.” A number of other respondents expressed different views, however. One agency representative and one judge stated that
few youth go to college. One social worker expressed concern that agencies do not encourage college but instead “they encourage kids to get their high school diploma or GED, get a job, and get the hell out of care.”

Employment
Only a few respondents commented on employment outcomes for youth who leave congregate care. Of all respondent groups, organizational representatives and agency representatives were most concerned about this issue. Organizational representatives emphasized that youth must have an income to have a stable living situation and focused on the importance of mentoring, career counseling, and career exposure before youth leave foster care. Agency representatives emphasized the challenges that teens experience when attempting to find long-term employment, particularly when they do not have job skills. One stated, “a lot of kids get jobs but they don't keep them too long.” Another commented, “[The] harsh reality is that it isn't easy [for teens] to find a job…They're at a terrible disadvantage because other kids can go home, and have physical and emotional resources to fall back on.” This respondent focused on the importance of helping youth to develop pre-employment skills, such as professional etiquette and understanding how to apply for work.

Personal connections after care
Judges, social workers and organizational representatives focused on the importance of youth's personal connections with others after they leave care. One judge noted that youth need connections with their families even if they do not wish to live with them and highlighted the importance of “any approach that establishes a significant connection with an adult who's really interested in the child.” One social worker stated that “we really need to find and strengthen [youth's] connections with adults who can be supportive after leaving care…” Organizational representatives made similar observations:

“There should be a connectedness between the resources a young person coming out of child welfare needs and the community that they are connected to.”

“Everything possible should be done to forge better connections with important people in youth's lives.”

Agency representatives agreed that teens in care need mentors or adults with whom teens can develop relationships. One agency representative, however, stated, “This is another unfunded mandate.”

Access to needed papers
Respondents commented on youth's needs for essential papers, such as birth certificates and Social Security cards. Agency representatives stated that “teens discharged from care…have access to their necessary paperwork,” and “[m]ost youth have appropriate papers…when they leave.” Other respondent groups, however, did not agree. Judges, law guardians, social workers and organizational representatives stated that youth leave foster care without their key papers in hand. One judge characterized the situation as “appalling” and as often requiring court orders to rectify. Law guardians and social workers also commented that court orders often are needed to ensure that youth obtain needed documents such as birth certificates and health care cards.
Immigration/legal status

Respondents also commented on issues related to obtaining documentation of immigrant youth’s legal status before they leave foster care. Both law guardians and social workers stated that many undocumented youth do not obtain legal status before they leave care. One social worker stated that “immigration is a huge issue” and reported being unaware “of a single case [of] an agency that has helped a teen get immigration status.” Another reported attempting to find paperwork for a child without legal immigration status and being told that all the needed paperwork was in a locked filing cabinet at the group home for which no one had the key. Organizational representatives expressed similar concerns and focused on the consequences for youth aging out of foster care. One organizational representative stated, “It’s sort of absurd to assume that an undocumented young person can leave the system into independent living when they can’t apply for Section 8 housing, they can’t get health care benefits, can’t work legally.” Judges, however, had different views of the extent to which agencies appropriately obtain documentation of legal status on behalf of immigrant youth. One judge stated that “sometimes” ACS obtains special immigrant juvenile status for youth, and another reported that the problem is more significant in boroughs with larger immigrant populations.

NEEDED IMPROVEMENTS IN THE FOSTER CARE SYSTEM

Professional stakeholders were asked whether there were aspects of the foster care system in New York City that should be changed so that youth in care would be better served. The following table summarizes their observations regarding needed improvements.

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<tr>
<th>Substantive Area</th>
<th>Overall Suggestion</th>
<th>Specific Approaches Needed</th>
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</table>
| Placements       | • Develop an array of more appropriate placements for youth.  
                     • Improve the quality of staff at congregate care facilities. | • Place emphasis on recruiting foster parents for teens.  
                                                                 • Separate youth in congregate care by age or by reason for foster care entry.  
                                                                 • Develop: a greater number of and higher quality placements for mothers and children, more diagnostic facilities, and therapeutic group homes; placements for youth close to their own communities; and smaller congregate care facilities so that they will be “more natural and homelike.”  
                                                                 • Require RTCs and group homes to be clean so that youth feel respected.  
                                                                 • Recruit staff who like youth and can work effectively with them, including bilingual staff.  
                                                                 • Hire staff with college degrees (or MSWs) who have knowledge of child developmental issues.  
                                                                 • Increase funding to attract, train, and support more highly qualified staff.  
                                                                 • Lower staff-to-resident ratios.  
                                                                 • Provide strong supervision, including supervisory oversight and coordination of psychiatric hospitalizations, educational issues, and psychotropic medications. |
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<th>Substantive Area</th>
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<tr>
<td>Services</td>
<td>• Improve services for youth while they are in care.</td>
<td>• Conduct more thorough assessments of service needs.</td>
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<td>• Improve mental health services; educational services; drug treatment; family planning services and education about sexuality; legal services; clothing budgets; recreational services; and services for teen mothers and fathers.</td>
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<td>• Place stronger emphasis on youth's connections with family and caring adults.</td>
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<td>• Improve aftercare services.</td>
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<td>Safety</td>
<td>• Improve the safety of congregate care facilities.</td>
<td>• Have a doctor on staff at each facility.</td>
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<td>• Put stricter curfews into place.</td>
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<td>• Make greater efforts to secure personal property.</td>
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<td>• Conduct random searches to detect drugs and other illicit materials.</td>
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<td>Permanency</td>
<td>• Place stronger emphasis on youth's connections with family and caring adults.</td>
<td>• Make greater efforts to maintain youth's connections with siblings.</td>
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<td>• Place greater emphasis on family work, both “intact family work” (prevention) and efforts toward reunification with birth parents.</td>
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<td>• Place greater emphasis on visits between parents and youth.</td>
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<td>• Identify people important to youth before they entered care as well as others in the community with whom teens have a connection.</td>
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<td>• Develop programs for the fathers of babies, whether the fathers are in care or not.</td>
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<td>• Improve aftercare services.</td>
<td>• Develop therapeutic supports for reunification.</td>
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<td>• Develop community-based resources and supports for teens.</td>
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<td>Youth Involvement</td>
<td>• Place a greater focus on youth involvement</td>
<td>• Develop leadership opportunities for youth to teach them ways to advocate for themselves.</td>
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<td>• Involve youth in their Service Planning Reviews (SPRs).</td>
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<td>• Ensure that youth attend their court proceedings.</td>
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<td>Transitioning from Care</td>
<td>• Improve transition services for youth preparing to leave foster care.</td>
<td>• Assist youth in getting part-time jobs starting at the ages of 14 to 16, enabling them to have work experience and better preparation to support themselves when they leave care.</td>
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<td>• Provide opportunities for youth to obtain concrete vocational services, skills-building, employment preparation, and job connections</td>
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<td>• Provide every youth with a savings account in which ACS or the private agency matches the amount the youth saves.</td>
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<td>• Ensure that each youth leaves care with health care coverage under Medicaid.</td>
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<td>• Place greater emphasis on helping youth develop a sense of their own abilities and roles in the community.</td>
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<td>• Improve the quality of independent living services.</td>
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<td>Systemic Improvements</td>
<td>• Strengthen interagency coordination</td>
<td>• Develop better coordination among the appropriate agencies regarding mental health services, housing, and education.</td>
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<td>• Strengthen the role of the courts.</td>
<td>• Improve communication by providing complete reports to the court that contain details regarding the child’s adjustment to care, service needs, the child’s educational status, and an assessment of how congregate care is or is not working for youth.</td>
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<td>• Ensure greater private agency accountability.</td>
<td>• Provide training for judges.</td>
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<td>• Address the funding constraints of the current structure and environment.</td>
<td>• Develop greater judicial involvement in the community.</td>
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<td>• Develop clearer standards of accountability for private agencies.</td>
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<td>• While recognizing the problems that ACS faces in the current budget environment, examine the roles of state and federal government in the City’s use of resources, particularly with regard to the funding limitations that some contract agencies face.</td>
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This section presents the key findings from interviews and focus groups with young adults. In the first part of this section, the findings from the individual interviews with young adults are organized by the six key domains on which the studied focused. In the second part of this section, the findings focus on the issues that were explored both in the individual interviews and the focus groups: what is working well in foster care for youth and what improvements are needed in the foster care system so that youth are better served.

I. FINDINGS FROM INDIVIDUAL INTERVIEWS WITH YOUNG ADULTS

Twenty-one youth were interviewed individually for this study. The young people's ages ranged from 18 to 25 years. Fourteen (62%) were female, 7 (33%) were male, and 1 (4.7%) was transgender. The young people had been out of foster care from 1 month to 5 years. They reported a wide variation in the number of placements that they had had while in care. One respondent, for example, reported having a single placement throughout her stay in care, but seven respondents reported ten or more placements. The young adults varied significantly with regard to their ages at the time they most recently entered care. One had entered foster care at the age of two months, eventually aging out of care. At the other end of the age spectrum, one respondent had most recently entered at the age of 15. All of the young adults had been placed in a group or residential care settings while in foster care. Approximately one-half reported also being placed with a non-relative foster family at some point during their foster care stays; about 15% reported they also had been placed with both a relative and a non-relative foster family at some point during their stays in care; and 25% stated that they had been placed only in group or residential care settings.

CONGREGATE CARE AS A PLACEMENT FOR YOUTH IN FOSTER CARE

With regard to their placements in group homes and RTCs, respondents discussed:

- Their views of congregate care as a placement option; and
- The aspects of congregate care that made it “good” or “bad.”

Views of congregate care as a placement option

The young adults expressed a range of views about congregate care. Some reported positive experiences with and favorable views of congregate care:

“I felt really good about [it]. In the beginning, I was upset because of my mom and everything. But I think it was a really good experience for me. I learned a lot of things that I wouldn't have learned with my mom...I didn't have all the doors open to me with my mom like I did in foster care. It was pretty good living...[in] my group home...It kind of showed me how to just deal with other people...I like found myself opening up more in group care.”

“It was a lifesaver. It helped me become a better person. It's what you make it. It can either be a stumbling stone or a stepping stone...When I first was getting ready to come into a group home, I never heard of a group home...It ended up being a good thing...everything ended up working out all right.”

4In this study, youth who had been discharged from foster care were interviewed. It is important to note that the comments of these young adults closely track the comments of youth who currently are in care, as revealed by the “Youth Speak Out” hosted by the Independent Living Resource Center, Hunter College, New York, NY of September 24, 2003.
“At first, I was scared because I didn’t know anything about the foster care system. All I knew was there was a group for girls who were not doing good at home or doing bad stuff. After awhile, I met some good people and I think it was a blessing in disguise…I mean, compared to other stories I’ve heard from other girls who’ve been in more than one group home, my group home was beautiful. We had beautiful floors and beautiful rooms with colorful curtains. It was real nice. Christmas time, the tree was so beautiful. We had a light. I mean, it was just wonderful.”

“When I first got there, it was like really hard to deal with because I didn’t want to be there and I was emotional. I couldn’t handle it at first. But after awhile, I adapted to it. It was pretty cool, you know. It was out of the city, it was upstate. So, it’s all right.”

Other young adults, however, reported highly negative views of congregate care:

“Like I’ve said, I always wanted that home structure…I feel like group homes and stuff like that, it feels like an orphanage to me. Like they don’t want me…I want to be with a family…I want to go out with a family. Do regular things that you see everybody else doing. So, the group home thing just always made me feel like I wasn’t wanted.”

“I felt more like a product than a person. It’s like, ‘fill up the beds.’ I look now and remember interactions and the kids were like treated not as a person but almost like a product. Or just not there…I just feel like it was kind of bureaucratic. Like robotic. I don’t know how to explain it. Everything is done systematically.”

“[At my group home], they teach you a lot but they teach you a lot of bad things and good things. I learned a lot of awful stuff there that I wouldn’t have wanted to learn…It was a very weird and mixed experience.”

“Just the whole group home thing, I think it tends to make foster kids mean and being that I had a lot of friends that was in it. It just tends to make them wild.”

Some respondents, having had placements at more than one group care facility, commented on the variation in facilities. One young adult, for example, said:

“Some were better than the other ones. A whole lot better! Their schooling, they keep things clean, especially the food. And the people that work there. They care. They try to help you. They bring stuff to the house, which they’re not supposed to. Be able to eat. Or clothes to put on. [Others are] dirty. [Staff] have attitudes. They know that we [are] in the system already and they’re like, ‘well, I’m just here for the money’…They talk to us, like we ain’t nothing. Because we are locked up and we have no choice but to listen to them.”
What made congregate care “good” or “bad”

Respondents commented on what made group care a good experience for them and what made it a negative experience. In a positive vein, some young adults stated that their group care facilities:

- Provided them with shelter;
- Provided them with adequate, healthy food;
- Provided them with medical care;
- Supported them in caring for their babies in mother-child facilities; and
- Offered a range of good programs, including educational and recreational opportunities.

Two young adults said that their group homes were their families. One said, “They loved me,” and another stated, “It felt like home…I could come home and be like, 'I'm home,' and everybody is around the dinner table.” Others highlighted their positive experiences with staff members who were strong role models and who showed that they cared. These respondents said:

“What they do is they give us advice every day…We look at them, like they have a nice car and they would tell us if we want that, they tell us what we got to do. ‘You can’t be bullshitting, like cutting school, hanging out with friends and smoking weed and stuff…You know if you finish school and go to college and do your thing, you’re going to have that.’ So that’s why I always listened to them. I did. It helped me out…Like I had my supervisor, at my house…I remember he used to always come dressed nice. Everybody wanted to be like him. So the whole house changed. We had everybody going to school. He motivated a lot of people.”

“Staff was really good. Like there was one staff [member]…he was really good with me. When I got sick, he would bring the tea. He could just see in my face when I was upset. I would say, ‘I didn’t say anything.’ He was like ‘no, you don’t have to say anything. Your face talks.’ He could just vibe it, you know.”

“[The staff members] were like my mother…They let me learn on my own. They let me go through my cries and my suffering. But they were always there, you know. Like from a distance. They wouldn’t try to be on top of it. And that made me feel good, because it was like you’re not putting too much pressure on me but you’re not making yourself distant. You are letting me know that you are around, but when I ask for it. And that’s good to me…The people that you live with, who work around you, the same people that see you every day, night and day, that watch you, the cooks, the people that watch over you – that’s the people that basically really helped me out. Told me things. How to do things. Who to hang out with.”

“I mean I’ve seen staff that literally do more than their responsibilities and I was fortunate to have those staff on my side. I mean staff that would literally stay there. I had a staff that would actually do my laundry if I was out of the program, and she watched my son when he was born. She watched him grow for two years.”
Other young adults described aspects of congregate care that they found to be highly negative. These issues included:

**Group care was not homelike.** One young adult stated, “It’s something they need to do to make the home feel less like a group home. It needs to be more of a family environment…It’s just the setting. They have the whole office setting. It doesn’t look like a house.”

**Residents did not receive enough food or money to meet their needs.** One respondent reported that food sometimes would be gone before all of the residents had eaten, and that residents were given too little money to meet their needs. “It was really hard for us because I had to ask other people for money and get food from somewhere else.”

**Staff were indifferent to residents.** Respondents said that many staff seemed uncaring and uninvolved. One stated, “I just felt like a lot of times, these social workers couldn’t identify with us because most of the social workers in these positions…came from different backgrounds. And those who did just became like more water to the cup in this bureaucratic cup of water. I don’t know how to explain it. Instead of changing it, they just conformed…you would see these new staff come in and they would want to change things and then they would just be so oppressed by what’s going on around them, that they would eventually give up. It was like, tiring.” Another said, “the staff, they even [would] say…’I don’t care, I don’t give a damn. These are not my kids. My kids are at home. I don’t have to do nothing. I don’t have to feed you all. My kids are at home’.”

**Staff behaved in a hostile way to residents.** One young adult said that her experience at the group home was “terrible.” “Everyday I was being told that nobody loved me and like my grandmother would call and she would upset me. [Staff] would say, ‘Oh, you see you are not loved.’ And they would just tell me a lot of mean things everyday. One supervisor would tell me, ‘oh, you don’t have nobody, you are not going to be nobody. You are not going to be successful. All you have is this here’.” Another respondent said that staff had told her, “at least I have a home to go to that I can afford,” and the respondent commented that this was “very cruel to say to a child. They said it every night to you. ‘At least I got a home to go to. At least I got a check’.”

**Physical facilities were dirty.** Respondents described some group care facilities as “dirty” and “nasty” with “disgusting” bathrooms. One respondent commented, “The inside [of facilities that look beautiful on the outside]…it’s like a car. Outside a car could be clean but the insides could be raggedy, you know. And that’s how it was.”

**Residents did not get along well.** Several respondents commented on the difficulties they experienced in living with a large number of other youth. One said, “Say if one person is in trouble and does something they are not supposed to, the whole house is hating them. The whole house has to suffer. Like that one person messed up, now we got to pay the consequences. I didn’t like that.” Another commented, “stuff clashes, because everybody’s got different emotions and stuff.”
There was no privacy. Respondents commented on having to share bathrooms with many other residents, and one said that she was not able to “just be by myself.” One young adult summed up the situation by saying, “Yeah…it’s like living in a shelter basically.”

There were too many rules. Some respondents said that they did not like group care “because they had so many rules,” many of which were “stupid.” One young adult stated, “The problem was [that] we [weren’t] allowed to go outside. [The] only outside [thing] we could do was go in the back. Go in the backyard and get some air. If we really wanted to play sports or something, we [couldn’t]. We could just sit in the back or sit down or listen to radios when they wanted us to listen to the radios. Play cards when they want us to play cards.”

Several respondents reported that they “would go AWOL” during their stays in group care. These respondents and others described repeated changes in their and others’ group care placements. Among their comments were:

“It was hard when I first got there because I didn’t have nobody. My family was not contacting me at all and I started going crazy. Not like mentally, but didn’t care no more. And I started getting in trouble and I moved around a lot. I never stayed in one place at all. The longest I stayed in a group home was for four years. And then other ones – it’s like for four months, twelve months, eighteen months and I finally got out of there.”

“It was OK for a little while. I had a lot of problems with staff. But they kept moving me from house to house because I had problems with staff, some of the residents there. So they moved me from this house over there to down there. Kept moving me around. I got tired of it, so I signed myself out.”

“I’ve always stayed in the same place but a lot of the other girls, they’ve moved around a lot. One week you might have a girl, the next week you might have somebody different.”

One respondent described her experience in the group home when it became known that she was lesbian:

“[They said,] ‘You’re a lesbian.’ I’m like, ‘wow. OK’.[And the staff said], ‘we cannot have that on the campus because we feel you’re going to…mess around with the girls and change them around and that’s not good. You know, turn them out.’ They made my sexual preference a big issue. And it’s like, ‘I don’t care’ – anywhere you go, there are gays, lesbians, transgenders. All over the place. They could at least tell me they have a place for me to go. Like put me in another placement. Even if it’s for gays and lesbians…No, they just left me there and decided, ‘oh, well her attitude is bad’…Oh, you got a problem with it? We can easily move you.’”
SERVICES FOR YOUTH IN CONGREGATE CARE

Respondents focused on several service areas:

- Education
- Counseling and support services
- Health care services
- Recreation

**Education**

Although two respondents reported positive educational experiences in their congregate care placements, most of the young adults expressed dissatisfaction with their educational opportunities when they were placed in RTCs and in group homes. Of the two respondents who had positive experiences, one stated that the group home in which he was placed provided tutors, a study hall which was mandated for residents if they wished to receive their allowances, help with homework, and motivation to succeed in school. The second respondent reported that her RTC had a job placement program, educational programs, and a requirement that all residents attend school.

Most respondents reported that they were not provided appropriate educational opportunities or programs. Three respondents stated that educationally, they had not achieved what they had hoped: one dropped out of high school because the program provided by the congregate care facility was too easy (she later obtained a GED); another reported having attended five different high schools while living in group care, dropping out of school and never having obtained a GED; and a third reported having gotten pregnant while in care, dropping out of a very poor quality high school but later obtaining a GED.

Several respondents commented on RTCs’ on-campus schools. Although one respondent stated that the RTCs on-campus school was “good” (giving it “about a B”), all others who commented on these educational programs found them lacking. Several respondents stated that they had not wanted to attend on-campus schools but wanted instead to attend a “regular” public school:

“I felt that if they [the RTC] had taken me to a public school, I would have graduated with no problems…I think them not sending you to a public school causes a lot of problems. It’s like being in jail.”

“The group home campus, I don’t believe, should have its own school. I believe these kids need to integrate back to the community, no matter what the community says. These are people, these are not animals. They didn’t do a crime. You don’t build gates around kids without a crime, without a record and then send them to this school…OK, there are kids with mental disabilities or learning problems. Send them to public schools with learning problems that cater to that. They’re all in the community.”
One respondent reported that of all the youth in the respondent's RTC, only three attended “an outside school.” When asked how many youth would have wanted to attend an outside public school, this respondent replied, “I would say almost everybody.” Another respondent who was able to attend a public school stated that “when you first come to the group care facility, you have to attend their educational program first. And when they feel like you deserve it or feel like you have any education or that you're smart then they'll say you can go to [a school] outside.” This young adult, however, reported that “you have to come straight back afterwards…if you weren't going to [their] educational program, you had to go to school and come straight back…I got out after school and came straight back. It was like we had curfew…because we weren't allowed out.”

Respondents described a number of specific problems with on-campus schools at RTCs:

**Automatic placement in special education.** One respondent stated that everyone in the RTC on-campus school is “automatically in special ed.” Regarding his own experience, the respondent stated,

“And I felt like, you know, when I was young I was in special ed because…I think it's called ADD. They said I had Attention Deficit Disorder so I was like really hyperactive, but I didn't really have a learning disability. I was just really hyperactive and growing up. And up until I got into junior high school, I wined up passing some tests to get me out of Special Ed. So why would I want to be back in Special Ed [at the RTC]?”

**The placement of all ages together in a single class.** Respondents expressed frustration that children and youth of all ages were placed in the same classroom. One stated, “And everybody was going to the same class. We were taught the same subjects. I felt like that was a failure because a lot of the bigger kids already know that. Of course they are not going to be interested. They are not going to want to learn.” Another respondent reported, “the work was so easy that you didn't even want to do it. They were still giving me one plus one and two plus two and I was eighteen.” A third respondent said, “It was terrible! How can a 12th grader be in a same class as a 6th grader?! It doesn't make no sense to me…And…you're a 10th grader and you are sitting there with a 6th grader and she's teaching you your time tables and you already know and you are like this…sleeping while the 6th grader is really the one who's trying to learn.”

**Overworked and underpaid teachers.** One respondent said that the teaching staff is demoralized at RTCs. This individual stated, “There are some teachers that do care, but I think some of them are underpaid and…given too much work.”

Other respondents focused on educational issues in group homes, where youth are supposed to attend public schools in the community. Several respondents stated that group home staff do not encourage or support residents' school attendance. Their comments included:

“[Group home staff] did absolutely nothing in trying to push me to go to school. You have guys that's in the house and girls that's in the house that [are] supposed to go to school say ‘I'm not going to school and I'm staying home.’ And they did absolutely nothing…If they don't go to school, that's on [the staff] – [they should do] whatever it takes to make [youth go to school]…don't let them stay home sleeping be the reason for why they didn't go to school…No kid should be in the house if there's school.”
“…they told me I had to go to school and they [the group home] wasn’t giving me carfare to go. So, how am I supposed to go to school with no carfare? And they called the truancy cops and I’m like ‘yeah, well how am I supposed to get there?’ ‘Well, we don’t know.’ So, I had to hope the train.”

“Some group homes didn’t put me in school facilities because ‘oh, you’ll be leaving soon anyway’…So, by the time I went back to school, it was already the middle of the ninth grade, which was like a year already had passed. And I lied to the school. I lied to the group home and to the school telling them ‘yeah, I’m in the ninth grade’ cause I really wanted to be up to my thing. And then, I didn’t go to school after that for like 3 or 4 months.”

One respondent said that although there are “a lot of services out there for people in foster care,” including educational services, the respondent did not have access to them. This individual stated:

“I don’t know if it was because I was a homosexual and I was open about it too. There were certain interns[hips] that I wanted to apply for, certain educational programs like trainings that…I wanted to do. They didn’t let me…Services that they provide that I wasn’t getting and I didn’t know why.”

Counseling and support services
Respondents expressed different views of the need for counseling and other supportive services for youth in congregate care settings. With regard to the need for more formal mental health services, respondents had a range of perspectives. One young adult said that group home staff had offered her a therapist’s services but that she had said no and staff had not asked again. “I never really wanted it anyway.” Other respondents thought that mental health services were essential for youth in group care. Some reported regularly having sessions with psychologists, but others said that therapy was lacking and that staff did not help youth understand the importance of this service. One respondent said that she did not receive enough emotional support and commented, “That sucks because if you say ‘I don’t want to talk about it,’ that was enough. To me, they should put more pressure on it, but…they weren’t very sensitive to anything.” Interestingly, this respondent said that staff relied on her to provide support to other residents who had been raped:

“I will give it to [the group care staff], they are very smart because they take advantage of your experience. My experience was that I was raped for years [before care] so they gave me some therapy and…anytime a child would come that had just gotten raped between the ages of 12 and 18, boy or girl, they would ask me to speak to them…But the therapy, they didn’t do very good with that.”

Respondents said that mental health services could be improved in a number of ways:

Therapy should focus on talking, not on medication. One respondent stated:

“If you ask for counseling, you are basically asking for trouble. Because once you tell them you’re depressed, now they’re going to put you through a whole evaluation to see if you need
medication. And then if you tell them, 'look it – I miss my family.' I would rather…see how you and me are talking? I would much rather talk to somebody like this. Get my frustration out. Because then afterwards, I feel like the pressure is off me.”

Therapists should be aware of what youth in foster care have been through. One respondent stated:

“Working with kids that went through things, going through the system – they need somebody that went through that. Somebody who was raised like that, there's many people with backgrounds like…them. That's a person [that youth] can relate to. Because somebody that don't know nobody that's been through that, you can't relate with that person. So, the [youth's] not going to feel comfortable telling you how they feel. So they're going to lie to you about relating.”

Therapy should not simply involve assessments. One respondent reported that therapists would come to see youth but “used to just call me for doing IQ tests and asking me how did I feel and basically assessment questions.”

Therapy should be one-on-one. One respondent said that in her facility, “They didn't have, like, one-on-one settings…Like everything was a group thing. Like if they were going to talk, they were going to talk to about at least five, six girls at the same time…But it's hard to talk to a whole bunch of people when they're all in your business. Because some people are private. They don't want to tell their business to everyone.”

Therapists need to be well matched to youth. One respondent reported that he had become extremely depressed while in group care, lost 100 pounds in three months, and withdrew from everyone. He received therapy three days a week, but stated that it did not help “because for one thing, it was a female and she was real pretty so I couldn't pay attention to her. I just looked at her most of the time.” When asked if he might have done better with a man, he stated, “Yeah. I had a man at first but then, he got fired or retired.”

Respondents had different views of psychiatrists. One said, “If you have any problems, [psychiatrists] make sure you [are] OK. They put you in rehabs, drug programs, anything. Anything that you have a problem with to see a psychiatrist.” Another, however, said, “The psychiatric doctor, they look at you like you're psychotic. If you [are] going to a psychiatric doctor, they think you're psychotic too.” Nonetheless, this respondent liked her psychiatrist, saying that her doctor “was cool. She used to bring candy and stuff like that.” A third respondent reported that he had seen a psychiatrist but “then I stopped going because I knew that I wasn't crazy…I felt like she wasn't going to understand me…So, it's like I didn't want to speak to her because I thought they were trying to say that I am crazy.”

Respondents also described their relationships with the social workers and other staff at their facilities and the emotional support that these individuals provided. Two young adults reported having strong relationships with social workers. One described a relationship with one social worker who “was great.” “My social worker, I always dealt with because I confided in her. Because she worked with me and she seen my potential.” Another reported having “been through four social workers in that same group home and they were all good.” This respondent stated:
“I hated saying good-bye, but I had to. They were all really good with me. They always helped me out. I don’t think I could ever say I disliked any of them. They just listened, you know, and sometimes, that’s all you need. And I could have been cursing and screaming and they wouldn’t be like my mother; she screamed back at me. They’d just sit and listen and then you’re done and then I’d be like, ‘yeah, I’m done’. And then they’ll tell me what they have to say and that was a really good experience.”

Other respondents described supportive relationships with other group care staff. One young adult stated:

“When I lost my grandmother a couple of years ago, I had so much support from everybody. From the girls, from the staff that worked there, staff in the office. I was pretty close to everybody and I still go back time to time to visit the girls and talk to the girls and visit Miss Rita who’s my mother. I call her my mom.”

Another said that youth go to “the regular staff that’s working there, you know…the cookers, the people who watch the kids. They were [the people to whom] we could relate. So I called them the parents. They were really like the psychiatrists.”

Three respondents mentioned mentoring as a source of emotional support. One respondent focused on the need for individual attention, such as through mentoring:

“I think they should have worked more closely with people who look like they weren’t going to go anywhere. They used to call them the bad ones…like work independently with them. Not work with them as a group. And spend a little extra time on that person. Like be a mentor or something…somebody with more experience, older than you who knows about life. Not some person who was born rich or something. A person who done been through it.”

One respondent described the benefits of having a mentor in the group home. This respondent said:

“One of the girls that lived in the group home, they would mentor you. They would show you around…Somebody who’s been there longer. They could have been younger than me, but if they been in the group home longer, they would be your mentor and they would get a stipend for it or whatever. And my mentor was really good with me. We did so much together. We did recreation. She showed me her house. She showed me the ropes. I think that was good because it’s not like just staff is telling you…it’s the girl and you getting to know each other and introduce you to other girls. And it feels more…it’s more comfortable that way. I think that was a good idea …I was a mentor, too, many times. Three times.”

One respondent described her relationship with a mentor from the community, a “big sister,” and related some of the limitations on this relationship:
“I had a big sister that I asked for myself. And she was the one when I needed to get away that would come and get me away. And I lost contact with her. I feel so bad. After a while, me and her didn’t [get along well]…because [I] was her first [mentee in foster care]…all the other kids she had where she was like mentoring basically rich kids, but she was like taking these rich kids out cause their parents were too busy. So when she got a foster child, she got kind of scared. After awhile, I started telling her what was going on. She started seeing that I would run away. She got scared because she didn’t understand. She was like, ‘well, why are you running away? You should stay.’ And [the group care staff] are telling her that everything is peachy and nice. And I was telling her ‘no, it’s not.’”

**Health care services**

Respondents addressed three issues in connection with the health care services that they received while in congregate care: the overall quality of health care services; the use and management of medication; and sexual health and reproduction services.

The overall quality of health care services

Most respondents gave good marks to the health care services that they received when they were in congregate care. Among the comments that they made in this regard were:

“They always tried to get me to go to doctor’s appointments and stuff…If you did need something, they were good at that and they would get it to you right away.

“Health care was perfect. There was no time that I didn’t need to go to the doctor and my Medicaid didn’t work at all. Once you are in care, they make sure every six months you go get a check-up. You go do whatever you need to do. AIDS tests, everything. These things were always done on the regular. I have no complaints about health care. That was always there for me.”

“They make sure you go to the doctor. If something is wrong with you, they bring you to the doctor. That was good.”

“Health services…are the only thing I can say I was getting while I was in foster care in the group homes. I was in school and like I said whenever I needed it, I got health services and that was it.”

Some respondents, however, found that health care services were lacking in some ways. They focused on the lack of dental care; long waits for follow-up medical care; and failures to refer youth to medical specialists. One respondent expressed concern that blood and urine tests were done without the permission of youth. “They would say it was just a physical and then when the blood tests used to come back, they used to want to penalize me…That’s why I didn’t want [to go to medical appointments] because then they would have to get the report of why I went to the doctor.”
Respondents expressed a variety of views regarding the use and management of medication, in general, and psychotropic medication, in particular. One respondent stated that medication was appropriately used and supervised. This respondent said, “They give you medicine whenever you need it. They don't want you to exceed and take too much. So I like the part that they don't allow you to take your medications to your room, you have to come to the clinic.” This respondent, however, also noted that there were some lapses in procedures:

“But sometimes, they were lax when it comes to medication because I remember a lot of kids who had AIDS especially. One of my friends who at the time was 12 and she should be like 14 now. She had AIDS, chronic AIDS. Because she said she didn't want to drink her medication, they would forget at times to take it to her.”

Another respondent also described lapses in the supervision of medication. This respondent said:

“I've seen a lot of medicine. I remember they had this kid in my house...And they used to have him on medicine. And his medicine used to make him urinate on himself while he was sleeping. It was like crazy. We would go in his room and it would just smell like I don't know. And they just kept giving him this stuff.”

One respondent stated that youth in RTCs, group homes, and family foster homes were “guinea pigs.” This individual said:

“85% of them are on medication and that's not good. God forbid, as an example, if you have a kid and for some reason, say you got sick and you couldn't take care of your kid...[and] they go into a foster home? They automatically [are] going to be put on medication because they say the baby is going to be depressed when they grow up. And that's not good. That's wrong judgment...If you like to play around a lot, if you like to go run around the field...they say, 'oh, you are hyperactive. Put him on like 300 milligrams of Ritalin.' That's not right. Kids, when they're young, are hyperactive. The reason why I say it is because I was on it. I had Depokote, Ritalin, one with an N. I had so many, I can't even remember all of them.”

Another respondent also reported having been required to take psychotropic medication:

“It got to the point where they started medicating me and telling me that I was hallucinating. And I was like, 'I'm not hallucinating.' ...They threaten you. So, you either take it or be embarrassed. I would just take it and stay quiet. And then I would go speak to the doctors. One time, they [put me on] medications that knocked me out for two days. And then when they sent me to the hospital, they didn't send the hospital my proper records. They hospital gave me two medications that I was allergic to and I almost died. I almost died because my airways started closing.”
Sexual health and reproductive services
Respondents reported different experiences with regard to sex education and access to family planning services when they were in congregate care. Some respondents had access to sex education in their group homes; others reported access to such information through agency-sponsored independent living classes (although the respondent noted that these classes were not offered to all the girls in the home); and others said that information was available through the RTC's adolescent clinic. One respondent said that at the group home, it was very easy to talk about sex: “We could talk about anything – whether it be a boyfriend or…what's going on in school or your personal life. We could talk about anything. So I never really felt that I couldn't say how I felt about sex.”

Respondents had different experiences with regard to access to condoms and other birth control. In some cases, staff made appointments for young women to see doctors who would then prescribe birth control, and, in other cases, staff provided condoms (one respondent said, “You never was afraid to get [condoms]…I don't care if you was a female, a staff or nothing. You come in there, and get some condoms”). Other respondents reported availability with some limitations: condoms were provided only if youth requested them or condoms were provided but “not frequently.” One respondent, however, reported that she did not have ready access to birth control in her Catholic group home:

“Birth control? I had to sneak my birth control and I had to take it because my period was irregular…So, they wouldn't give it to me. They wouldn't pay for it. Because they are a Catholic agency. So you can't get it. So, I had to sneak mine in. So the doctor would sneak it in for me.”

Three respondents commented on pregnancy and abortion:

“There [was] a lot of intimacy going on up there [in the RTC]…It's like [the staff] care, but you can tell that they didn't care the way they was supposed to. Because girls were up there getting pregnant and that wasn't supposed to be going on. Especially when the boys' cottages [were] like, a whole mile away. So, like the guys were actually finding a way to get to our cottage…”

“Kids don't want to be in the system so…girls would get pregnant to leave. Because once you leave you can go to a mother/infant program. From a mother/infant program, you can move to a Section 8 apartment. So, I got pregnant there…”

“So, there are so many abortions…I mean if they did a study about how many girls get pregnant in foster care – I think they would find high numbers…And how many in these RTCs, because they are not suppose to leave campus, how many of these girls are getting pregnant from guys that are on campus?”

Recreation
Some respondents reported very limited recreational opportunities while other respondents described a wide range of recreational and travel opportunities when they were in congregate care. One respondent, for example, said, “After school, I just really went and hung out with my friends and smoked and drank.”
That was my thing. To me, there wasn’t [recreation made available through the group home].”

Other respondents reported having recreational interests that they were not allowed to pursue in care:

“When I first came to the group home and was 14 years old, I was coming from Harlem and I [was] just starting high school. I [had gotten on] the football team for high school. I made the team, but I had to go to boot camp [for the team]. And I needed the money to go to boot camp. But then me and my family had the problem and I ended up in the system. And I had asked the system, ‘can you pay for my uniforms and stuff like that?’ and they told me that they couldn’t do it. So, I didn’t make it to the team. So, I was disappointed. I asked them several times…So the time I could have been in practice, I was doing something else. I was doing something bad, instead of playing football.”

“I remember I was going to karate school and they said they would pay for it and then they stopped paying for it. I remember that day I had to tell the other guy in the school that I can’t come no more…I think I was doing good…They said I was a threat with the karate or something like that. That’s what the social workers were saying, they had a meeting to cut me off of karate school.”

One respondent said that she became involved in activities through her school, doing “anything and everything to get me out of that house I was in…I was in everything. I played football. I was the only girl on the football team. I played basketball, girl’s basketball. I played softball. I played hockey.”

Other respondents reported that they participated in a range of activities while living in their group care facilities. They reported the following as being “a lot of fun”:

- Singing in a choir and traveling to Syracuse and Niagara Falls;
- Jogging and exercising with a gym teacher;
- Taking dance classes;
- Visiting museums in Manhattan;
- Shopping trips;
- Apple picking;
- Going to movies; and
- Traveling to Great Adventure, Hershey Park, the Poconos (for skiing), Washington, DC, and Vermont.

In addition, one respondent reported celebrating Hispanic History Month in the group home. This respondent said:

“We would all cook something from our country or whatever…you cook and do decorations because I was always into art so…And I painted two pictures on their wall. I do abstract paintings. So, I painted…but they always encouraged me. And my paintings are all over there.”
SAFETY OF CONGREGATE CARE

All respondents commented extensively on safety issues in congregate care facilities. A few indicated that their facilities were safe, control was well maintained, and discipline was used appropriately. Many others, however, described their facilities as overly restrictive, not allowing youth any flexible use of time or privileges, or so free-wheeling that there was no control. The young adults focused on:

- Specific safety issues in congregate care;
- Going AWOL because of fears for safety; and
- The role of staff in ensuring safety.

Specific safety issues
Respondents identified a number of specific safety concerns in congregate care: peer-on-peer violence, threats, and intimidation; weapons and gang activity; staff violence against and intimidation of residents; resident violence toward staff; stealing, inappropriate and illegal staff conduct; inappropriate use of restraint and isolation; lock outs for curfew violations; prostitution; absence of security measures at the facilities; and dangers to youth outside the facility.

Peer-on-peer violence, threats, and intimidation
Respondents recounted a number of incidents in which other residents of the facilities physically harmed them or others. In many of the instances, the young adults said that staff did little or nothing to protect the youth. Four respondents reported that either they themselves or others they knew were raped while in congregate care. One respondent, a transgender young adult, reported that four males raped her at a group home. Another respondent reported:

“I got raped in that group home. And when I told staff what happened, they said, ‘oh, no that didn’t happen. You are a faggot. You like those kind of things to happen to you. Maybe the boys pissed you off and you decided to tell on them.’ Or they thought I was crazy or that I was lying. And then…they sent me to another group home and the group home that they sent me to in Harlem when I was there, I went through this whole emotional breakdown thing. Like I started crying and saying that I wanted to kill myself because I had got raped and because I was beaten.”

Another respondent reported being sexually assaulted by a staff member. “One staff actually sexually assaulted me and they didn’t do nothing about it. And still haven’t done nothing about it. [I told] my foster care agency. I told the supervisor. And he still works there.” Yet another respondent reported repeated rapes on the RTC campus and stated:

“What bothered me the most was that …there was no structure. We had cameras in the school but they didn’t see the rape and it was in the staircase where the girl had gotten raped. The guy got caught and got arrested, but being that it was a first offense, they let them go like it was nothing.”
A number of respondents described fights among residents in which the police intervened; residents starting fires at the facilities “for the hell of it”; and campus riots requiring police intervention. One respondent described her own experience with personal violence:

“My room was on fire once just because this girl didn't like me…The girl who set my room on fire got arrested. I was unconscious on the floor because she had beaten my head against the wall. She was a huge girl. I wasn't pregnant at the time, thank God…When I was pregnant, I had a couple of incidents. I had this girl that constantly bothered me and once, she started a fight in the cafeteria, and I got hit with a table. The table got thrown at me, and I was about four months pregnant.”

Respondents commented on staff’s failure to establish and maintain control when fights broke out. One respondent reported, “they really don't stop anything. If the fight goes on, it's going to go on until the cops get there. If it's not stopped by that, then it gets…bigger.” Two respondents stated that staff instigated some of the fighting:

“There were certain staff that if they didn't like one of the girls, they would put one of the girls they did get along with to fight the other girl, which they do a lot at group homes.”

If they [group home staff] don't like one of the girls, they'll get one of the girls to beat them up. They'll pay them. They'll give them money. They'll do anything. They'll try to bribe you to do anything and I was one of them who did listen to the staff and did what they say and get paid for it. You know, for beating up one of the girls because I didn't like them either.”

Two respondents reported being “jumped” by other residents. One described the situation as follows:

“In one of the group homes that I was in, the guys, they were so mean…They would always pick at me and call me names. They would throw things at me when I walked down the hall. I would go to school and I would come home and I always cut through the high school and these same four guys, two of them lived in the group home and two of them, I guess, were their friends. They would jump me everyday coming home from school. That's so not nice. There you are – someone young in the system and everyday coming home from school, you are being jumped by these boys and the group home is not doing nothing about it. And they know what's going on. They know and I told them. All they could do was send me off, get me a safety transfer.”

Other respondents described how residents threatened and intimidated others. One respondent reported waking on her first night in her group home to find “all this stuff on my hair that these girls had thrown [on it] and I had to go to a barber shop the next morning and get my hair cut.” Some said that the intimidation led them to believe that they would have to aggressively defend themselves. Respondents stated:
“When I started smoking [crack], I got into a lot of fights. Girls used to shove me around and I used to stay quiet and I used to let them hit me. And you get to the point where after a certain amount of time you could take but so much so that’s when I started carrying my blades on me. I got into a couple of fights there cause I had a knife.”

“One of the kids…was being bullied by these kids…This kid was bullying him and tried to force him to do sexual things to him. So, he cut him.”

Weapons and gang activity
Several respondents described gang activity in congregate care facilities and the presence of weapons. Some reported a high level of gang activity in group homes:

“What’s happened in foster care [is that it] has become very gang infested…Because these kids are looking for the assimilation of the family thing…And what these gangs are doing are assimilating themselves to be family…Not everybody joins these gangs. Don't get me wrong. But a majority of [residents] do. If you go into any group homes today, it’s most likely I would say 50% of the group home is gang-related.”

“They got a lot of gang-related stuff – Blood, Crip…a lot of that is in group homes nowadays where a lot of kids don't feel safe. Especially young kids…I see some of the kids up there, they bully the kids. And sometimes the staff would know, and they wouldn't care. A kid [might] run to the staff and the staff [would] be like, ‘handle your own business.' You know that a kid can't handle his business.”

“The gang activity [in the group home] was ridiculous…Once you are in the gang, it’s hard to get out and they want you in a gang because you are smart or because you know how to fight...[If] you don't want in it, they will pound you and pound you and pound you until you come in. That happened to me. They wanted me in a gang called ‘Bloods’ which is one of the worst gangs anyone could be in. I almost got my face cut because that's the first thing they do. It's an initiation supposedly...What they do is they take a blanket and they put all types of items that are in your house, like any hard items and rocks, and they put it in there and they come to your room and give you a blanket party. They tie up all those items [in a blanket] and they hit you with it...I had to jump out the window.”

“I didn't really want to be there because there was a lot of gang-related people. There was a lot of the ‘bloods’ that used to hang out in front of the group home. Most of the girls that lived in the house were bloods. So, I used to leave, come back after a couple of days…”

Several respondents stated that group homes do not detect weapons that are brought into the facility. They reported:
“Most group homes, they don't search you...They don't look through your stuff or whatever. And the girls that do go out there and sell themselves...knowing what they do – staff [know that they] have weapons with them...Every group home you go to, there's always a blade or a knife...But staff don't know that...So most girls, they carry weapons.”

“They would get guns and drugs two blocks from the campus. There was this little site where a guy with a van would sell the items. We got on allowance so all you had to do was save it up or steal it from the receipt box and [buy weapons with] all that money that we had stashed up...”

“[In group homes], they don't search you when you go in. The RTC, you do get searched every time you leave and you come in. But not the group homes. And that's where you have most of the problem in the group homes and the foster homes.”

“It's easy to bring weapons into [group homes].”

One young adult also reported that residents sold guns to staff.

Staff violence against and intimidation of residents
Three male respondents recounted incidents in which a staff member had physically assaulted them. In one situation, the group home worker beat the respondent because he behaved disrespectfully toward him:

“He hit me first. I remember he was throwing me around in the room. I remember he had hit me pretty hard, I was knocked down. And when I woke up, I had pain right here in my face. I was unconscious. And they never did nothing about it. I made a report, he didn't get fired or suspended or nothing. A matter of fact, they kicked me out of the house, and they moved me to the Bronx. They took his word over mine.”

Another respondent reported that a staff member had attempted to strangle him:

“He used to just come in sometimes drunk. And he would come in angry sometimes...He beat up just about everybody in the house...And I remember we all used to tell [the supervisor] about Mr. B [the abusive worker]. He used to overlook things. I guess him and Mr. B. were real good friends. But then it came to the point where...we fought back...”

A third respondent described a physical incident precipitated by a staff member:

“I remember one day, I wanted to use the phone and it was late at night and [the staff member] went and I was on the phone. He rips the phone from out of my hand, he puts it in the drawer, so I was like 'that was stupid, I don't care.' I went to get the phone and he goes, slams my hand in the drawer, my hand stuck in the drawer. And I'm telling this guy, I'm like 'Mohammed, get off my hand' and he's just looking at me like 'no' and I'm telling him, 'get off my hand.' So I jerk at him like I'm going to hit him, and he flinched and gets off. But I wasn't going to hit him. I
just needed to get him off my hand, because he had my hand pinned in the drawer. So, he’s like ‘yeah, go ahead hit me, go ahead hit me.’ I’m like, ‘Mohammed, I’m not going to hit you.’…So, he goes to the other staff and tells the other staff that I punched him in the chest and he called the cops. Calls the cops and the cops come and he tells the cops that I punched him in his chest, [and that] he got asthma.”

One young adult described intimidation by a staff member:

“I felt like [the staff] did nothing because I complained about [the threats] and it was to the point where I was like, ‘I’m going to hurt him and y’all not doing anything to protect me from not hurting this guy because I’m telling you what this guy is doing and how he continuously messes with me.’ There were times when I was sleeping and I [would] wake up and he was over my bed. I [would] wake up and he [would] be over my bed and he [would] say ‘see, I can get you.’”

Resident violence toward staff
Two respondents described incidents of violence on the part of residents against staff. One respondent stated that a resident had put Clorox in ice cubes which one staff subsequently ate and that residents arranged for “people [to] come in and beat up the staff.” This respondent stated, “They’ve hit the staff and the staff aren’t allowed to hit back at all – so what do you do when you are being attacked?” Another respondent reported that when a resident struck a staff member, the resident was arrested but returned to the facility two months later. “[It was] like they were gods because they got arrested, like it was something good to them.”

Stealing
Many respondents stated that stealing was a serious problem in congregate care. Among the comments they made were:

“Some [residents] are thieves and they could steal your things. So it’s always a problem.”

“The only thing that was hard for me was studying, bringing books home and it’s hard because they’re like $200 books and you worry about someone trying to steal them from you…people were constantly getting things stolen from them.”

“I used to want to go to school, but I went to school and my stuff would be stolen. Your stuff was never safe.”

“Girls used to come in your room and they steal your things when you are sleeping…”

“I [would] come home and my sneakers [would be] missing. I would ask the staff, did they see anybody come in my room and steal my sneakers, they would be like – ‘no.’ They never seen nothing. The kid is walking around in front of your face with the sneakers.” “I had a whole lot of stuff stolen from me…I told [the staff]. It was like, ‘oh, we don’t know what you had.’ That’s what they said. They don’t reimburse you or nothing.”
Inappropriate and illegal staff conduct
Respondents described a number of inappropriate staff behaviors that compromised their safety and created an unhealthy environment:

Having sexual relationships with residents. Three respondents described situations in which staff members were sleeping with female residents. In two of the cases, respondents stated that supervisors refused to believe the young women who complained.

Using drugs at the facility. One respondent described his own drug use at the facility and explained, “The weed got there through staff members. The coke got there through staff members. And the heroin got there through staff members. The kids that were cool thought the staff was cool…‘oh, hey, he’s cool, he’s bringing me weed, he’s going to bring me this, well, I can hang around with him.’” Another said, “Staff used to smoke weed with me when I was in there…most of the time, it would be two staff on for each shift. Four hours out of the day, the supervisor would be there. When the supervisor leaves, it’s like the rest of the night is free. So, everybody just did what they wanted.” A third respondent said, “I seen more drugs in the group home than I seen in the streets. You have staff selling drugs, having the residents sell weed.”

Withholding clothing money as a punishment. One respondent said that staff would withhold money for a girl’s clothing “as a punishment.” This respondent stated that this type of behavior is “just going to make [the girl] act up more and want to not be at the group home more because she’s not getting nothing.”

Stealing agency funds. Three respondents described situations in which staff members stole money from the agency, either by taking petty cash or skimming money from youth’s clothing allowances.

Inappropriate use of restraint and isolation
Several respondents described the inappropriate use of restraint and isolation in congregate care facilities. Two respondents described how medication was used to subdue residents:

“I met staff that were horrible and still are. Because the staff stooped to your level and if you get upset, they are so quick to restrain you…So when they restrain you, they would throw you on the ground, not caring where you are, pull your pants down, stick a needle in you and put a medication that’s suppose to calm you down. It didn’t really do much because if you were upset, it really didn’t matter. But what it does is, it makes you like a zombie, makes you fall asleep. The restraining part was not necessary. If you came there as a good kid, you can actually leave as a bad kid.”

“And then there were times where they would restrain kids and then have this big guy come over from the clinic and give them like a needle…I’ve actually seen staff know that a kid [had] a bad temper and keep messing with him until the kid would go insane. They would restrain him and give him the needle. They tried to do that to me one time [but I was able to talk the staff out of it]. And then they let me go and I just went and walked off somewhere and actually calmed down by myself without it.”
Several respondents said that youth were isolated in small, windowless rooms:

“And they have this room that looks like a Bellevue room where it’s padded and they leave you there for more than 8 hours which I think is beyond ridiculous to put a child.”

“They had a box. If the kid ever got in trouble, they throw you in a box in the school. It’s like, probably, a little smaller than this room with just a door that they lock from the outside…They leave you in there for one hour, two hours. Sometimes they leave you in there the whole day. The whole day. Seriously. No bathroom in there…it’s small and they lock you in and they walk away…It was like being in jail.”

“They have a box. It’s a room with no windows, no lights. And they put you in there to try to calm you down. For numerous hours. It depends on how furious you were. Like…they’ll put you in there sometimes for like half an hour. And if they like you, you won’t stay in there for that long. But if they don’t like you, you’ll be in there for an hour.”

Respondents also reported being confined to their own rooms for extended periods of time:

“I was locked in my room for what I think was two days. Two days, that was my punishment. I was not supposed to leave the room…Everybody else went to school, went about their business and I was locked in the dorm. Now they’ll come and find out if you want to eat, but that’s it. I didn’t think that was fair…I mean school work is going on and I’m in my room. I should be there [in school]. I understand, yes, I did something wrong but at the same time, punish me in other ways.”

“[When you are placed on restriction], as soon as you come in the door, you have to strip and you have to go upstairs to your room and you cannot leave your room. They bring your meals upstairs to you. You have nothing on but your boxers and you’re up there for two weeks straight. In your room, 24/7. They bring the meals to you. You have five minutes to eat.”

Lock outs for curfew violations
Two respondents described being locked out of their facilities when they did not comply with curfew:

“One of the group homes was like if you came home after 12 o’clock in the nighttime, they wouldn’t let us in the house. So we would have to sleep on the street or find somewhere to go because they wouldn’t open [the door]. And legally, they were not supposed to do that. They were supposed to allow us back into the house…It wasn’t what the group home allowed. It was just that certain staff was a real bitch. That’s basically it. She didn’t want to open the door.”

“They wouldn’t let me in one night. I kicked the door. They had me arrested for that…Because it’s past my curfew. I kicked the door right in.”
Prostitution
Some respondents stated that prostitution was a problem in their group home environments. One respondent said, “I saw prostitution in front of the group home, which was really bad because I came home in the nighttime. So, you see the girls in front. You see the guys with them…Then you had girls trying to talk me into doing prostitution and whatever. But the thing was…I was listening to them but…I didn't want to do that stuff.” Another said that staff were aware of these issues but did not deal with them. “They had guys going up to the window talking through the window in the living room. And the staff says you are not supposed to do that, but they still let it go.”

Absence of security measures at the facilities
Respondents differed in their assessments of the security of their facilities. One respondent reported feeling very safe because the group home was in a nice area and “we had an alarm on the door. And [there were] a lot of good people around us. Just the area alone made me feel secure. It wasn't like I lived with my mom and it was in the projects. It [the projects] was scary. But there I felt comfortable, safe.” Other respondents were more doubtful about the security systems of their facilities. They said:

“We had side-doors like right by our room. Now this is upstate in the woods. Sometimes we used to sneak out, in the nighttime, to go smoke a cigarette or something like that. So, I thought to myself, if I can actually just sneak out the side door and there's staff there supposed to be watching us – then that means someone can break in and try to harm one of us.”

“So, we couldn't use the computer labs for a couple of days because somehow, one teacher left the door open while Ms. A wasn't there and they broke in. No security. There was no security! You could break into the school anytime you wanted to. We knew how to pick the locks. It was so easy…It's very easy for a person to walk on that campus. If somebody wanted to go in there and like God forbid, hurt someone, it would be nothing stopping them from doing it. It wasn't safe at all. It really wasn't safe.”

Dangers to youth outside the facility
One respondent expressed concern about the area in which the group home was located: “And they have shootings right in front of the group home. They had a shooting not too long ago. And they had drive-bys.”

Going AWOL because of fears for safety
Several respondents stated that they had gone AWOL because of fears for their safety in congregate care. One respondent, for example, said:

“They had the kids in it that was real violent. And they would try to bully you…The staff, some of them see it and some of them don't. A lot of kids, they ran away. Not just because they don't like the place. They don't feel comfortable sleeping there was because the kids are bullying them and staff like that…The reason I AWOLed from there was because I got up, the first night I was there, I got up. And they have gangs in the group homes. And these girls were Bloods. And they...at that time, I was supposed to be Crip or whatever. I got up and they was by my bed. Just standing up there with a blade in their hands. And they heard a staff come or whatever and
they ran. So after that, I was like, that morning I went up to the main office and asked to call my worker. And I told my worker what happened and she acted like she didn't care. She's like, 'stick it out, stick it out'. One of the staff told me, 'if you know where you're going and how to get home – leave. Because they are threatening your life and nobody is doing nothing about it'."

The role of staff in ensuring safety
Respondents repeatedly associated safety with the quality and responsiveness of staff. Some respondents reported that staff at their facilities made them feel safe. One respondent stated, for example, "At [my group home], I felt safe. I felt safe...because the staff was so friendly. They [were] so nice...Because I always stayed in the staff room, just talking with them. Chilling with them. Reading my poetry to them." Other respondents said that the ability of staff to control the group care environment varied significantly from one facility to another. A large number of respondents expressed dissatisfaction with staff and described feeling that staff members did not ensure their safety. Several focused on the ineffectiveness of staff in protecting them from other residents. One young adult, for example, said that staff put her in the living room to sleep because other residents were threatening to attack her. Other respondents made the following comments:

“I was told I was supposed to go to a foster home...and then I get thrown into this group home where when I get there, I'm like 'what is going on?' Girls are just running all over the place. Staff are going crazy. Kids are running around. It was just terrible. There was no control.”

“As far as other kids, I've seen other kids come in scared to their shoes...not really well protected by staff. Staff just overlooking things. Kids being beat up, jumped. And all that. It was not well protected at all.”

“So the staff don't make you feel safe. They let you know off the bat, they're there for their check, and they are going home. So you don't feel safe. There's a lot of kids that are afraid of the system so they rather go out of program and be in the street. It's funny because in the street they feel safer because they could roam around and go to their homes or their schools.”

PERMANENCY FOR YOUTH IN CONGREGATE CARE

In connection with their permanency goals while they were in foster care, respondents discussed:

- Reunification and family connections
- Adoption
- Independent living

Reunification and family connections
Only two respondents reported that their permanency goal while in care was reunification with their parents. Of the two respondents, however, one returned home only after being arrested and the second respondent never returned home:
“It took them years to help [my mother]. But it also took my mom years to get herself together. But when she finally got herself together, yeah, eventually, they got me home…They don’t help everybody…The way I really got out is when I got caught with a gun charge upstate in one of the group homes. After that, no group home wanted me.”

“Well, they made it seem to my parents that they were going to send me back home, but it wasn’t. It was never like that…Well, they would say, ‘oh, we are just waiting for your parents to do this, for your father to go to parenting classes and to get a bigger place’…They did all of that…They said that he didn’t go to parenting classes. He had the certificate. He had the proof. And they said, ‘oh, that’s not a recent one’. Once you got one, that doesn’t matter…It was always a reason why they didn’t want to let me go home. It always came up, new ones…I never actually went home.

One respondent reported that although her formal goal was independent living, her personal goal was return home:

“A lot of times your agency plan would switch up. One minute they say ‘OK, you know what, we’re going to send you to Job Corp.’ The next minute, ‘OK, we’re going to put you in the service.’ The next minute, ‘oh, we got an independent program, we’re going to send you down there.’ They tell you so many things at one time…It’s like your head is spinning and you don’t know what’s going to happen. Then it’s really, you don’t know what you want to do. That’s why I said that my one goal was always to go home.”

Respondents reported different experiences regarding maintaining family connections while in care. Some respondents wanted these connections but did not always receive help in making and sustaining these connections:

“As far as my family, they didn’t try to help me as far as focusing on my family, trying to make contact. It wasn’t the people who worked in the head office. It wasn’t them. The caseworker didn’t help me with that.”

“I’m from Trinidad and I wanted to go to Trinidad and see my father…I wanted to go down there and see him. And the upsetting part of it is I had to go down there and see him last year…in a casket. I went to bury my father. Which got me upset because you should have seen how fast they did the paperwork…And I wanted to go down there and see him for real, alive. And they never did the paperwork…Only when I got the call that my father died, they did the paperwork so fast.”

One respondent said that some residents looked forward to meeting with their parents and siblings and stated that when home visits were not allowed, residents would go AWOL to see their families. Other respondents, however, reported that their parents did not take advantage of opportunities to remain in contact:
“[Staying in touch with my mother] was probably not what I wanted. My mother...they used to invite her to see me and my mother wouldn't come. My mother wouldn't come to the team meetings.”

“[There were] two things I wanted services on. And that was for me to connect with my mother. Which they did. I was getting services for that. It was just my mom was stubborn. She wouldn't want to connect back with me. So the place was doing what they had to do. She wasn't responding...And another service was with my father which I'm still trying to locate him now...With my father, just trying to re-connect with him. I'm in the process of finding him now. They didn't actually [help with that].

“[My mom never came to [the meetings]. But they always made appointments so we could have family therapy with my mom there. But she would not make it. But it was like the first few times it bothered me but then afterwards, I just kind of got used to it. I mean [the agency] did their part. They sent her letters. They called her. They would call her the day before. They would call the same day a few hours before. I mean, I think they did their part. It was my mother. She was in her own world.”

Another respondent said that his mother attended meetings, but although she had no understanding of the issues, staff listened to her opinions:

“My mother would come to the meetings and...she would sit there and she knew nothing of what was going on...[Agency staff] would be saying stuff like 'yeah, well you know, J. is doing this which is good, but you know at the same time J. is doing this.' And, my mother [would say], 'I think that he should be in a more constrained environment.' Where you coming from?...I don't even see you...I'm not even talking to you and you come and you say what?"

Two respondents focused on their desires to maintain contacts with others in their lives. One young adult stated that she had wanted to remain in contact with her sister (who remained at home with their abusive father), but efforts were not made to allow her to do so:

“So I felt like that could have been done in a different way where I could have seen my sister...They could have had a worker bring her by the house to visit. I don't know. Something could have been worked out where I could have kept in touch with her and not [have to] go there to see her. That's the bad thing that really came out of it is that I lost touch with my baby sister. To this day, I don't know where she is at. I haven't spoken to her in years. She was five.”
Another respondent said that she had wanted to remain in touch with a former foster mother:

“*They never told me, ‘okay, you can go on visiting.’ Like in the beginning, yeah, I went back to her. But then after the third or fourth group home, they was just like, ‘oh, she doesn't have any family’. And I said, ‘How could you say that! You know, I have a family.’ And, they was like, ‘that's not your real family.’ And I said, ‘so what. If I ever am able to get visitation, I want to go there.’ They said, ‘no, you cannot’.*”

**Adoption**

Five respondents discussed adoption. Three stated that they were not interested in being adopted:

“For me being adopted? I mean, well, there was [some discussion] in the beginning. They asked me…there wasn't too much of a discussion. They just asked and I said no and they left it at that.”

“I was free for adoption but I didn't want to get adopted. My plan was to stay in foster care until I aged out or something.

“I told them I didn't want to go back home. I was like, man, I do not want to get adopted. I don't even want to be on the waiting list to get adopted…They asked me, but I told them I didn't want to be adopted. I don't want to be around no family. There's family I lost touch with…The only time I ever want a family, is if I'm married or I have kids…I can't trust nobody that didn't raise me or nothing. I would never in my heart feel like that's family.”

One respondent, however, said that she wanted to be adopted but was discouraged from believing that adoption was possible:

“I wanted to be adopted, but who would adopt a 16-year-old…One social worker told me [that] nobody wants to adopt a 16-year-old. She said, ‘who would want to adopt you? Let’s be realistic.’ You are probably right, nobody would want to adopt a 16-year-old.”

Another said that adoption was not discussed, but the respondent would have wanted the opportunity to consider it as an option:

“I don't remember anyone coming to me and asking me what did I think was best for me, or what would help me, what would I want…At that time, I didn't even know I could be adopted…I didn't even know anything about being adopted. And that's a shame…I should [have] known that it's a possibility I could be adopted.”
Independent living
Several respondents reported that their goal was independent living and said that they agreed with that goal. One respondent, for example, said:

“I just left a home years ago that, where I got violated and abused, so why would I want to go back there?...You don't want to go back. I think they should...give [kids] more options...There's adoption...There's independent living. There's kinship. You can be adopted by a relative. But my thing was I didn't want to go home anymore. I wanted to be independent.”

Finally, one respondent said that the goal was whatever he wanted to be: “The agency's plan was for me to make my own plan, to see where I'm going. That was really the agency plan.”

YOUTH INVOLVEMENT
Respondents discussed four issues in connection with their personal involvement in influencing their current situations and planning for their futures:

- Level of involvement in planning and decision-making
- Participation in Service Plan Reviews
- Self-assertion
- Other opportunities for involvement

Level of involvement in planning and decision-making
Respondents differed in their reports regarding the extent to which they were involved in planning and making decisions about issues of importance to them. One respondent reported that she made all decisions for herself:

“So, I made all my decisions. A lot of times, [the agency] didn't agree with it. But they let me make my decisions. They always respected everything...Whether they agreed with it or not, they always respected [me].”

Other respondents said that they were given opportunities to make some decisions, particularly regarding school and work. Most, however, said that their opportunities to be a part of the decision-making process were very limited.

Several respondents said that their wishes regarding their placements were not heard. Respondents, for example, reported:

“I told them I wanted to switch foster care agencies because I [had] lived [in] most of the group homes that they were trying to send me to. And it did not go well in those group homes...And I said, 'maybe if you switch the agency and then I'm around different people from different places then that's different'. But they didn't want to switch the agency. They were just like, 'no, we're not doing it, it's too much paperwork.'”
“I wanted to just stay in one place. I wanted to let them know what they were doing with me. Giving me more information. I wanted to be put in foster homes. But it seems like every time I asked them or I wanted that, it was like ‘no’… And really, I just stopped asking them, I stopped caring. Whatever they wanted to do with me, I let them do it. So, I never asked questions. Whatever they wanted, I did.”

“I didn't have a choice. My thing was I always wanted to go back to my second foster mother, and they was like, ‘that’s impossible’. [I wanted to go] where I knew I was wanted. And they kept on saying ‘no, no, you need a more structured place. If you could be in jail, that’s where we’d rather see you at’. And that hurts. You know how much that hurts that you could hear people telling you we’d rather see you in jail…you’re not fit for society…But I didn’t really have a say-so. They did whatever they wanted to.”

Other respondents said that their wishes regarding their permanency plan were not respected. One respondent, for example, stated:

“I told them I wanted to go with my parents, and I was never sent with my parents. I was basically pushed more away from [my] parents when I was living there than them trying to put [us] together. And if you are going to ask a person where they prefer to go, that means that you are basically going to move them there. Or you going to try your best to get them there. But it wasn’t like that. And ACS says that they are all about putting families together. It’s not true. They tell you something else but once you show up in court and you are in front of the judge – it’s all a total different story.”

Participation in Service Plan Reviews

Three respondents mentioned their Service Plan Reviews (SPRs). One stated that he participated in both his SPRs and in court proceedings:

“I went to my service plan [reviews]. Like they used to let me know when I had my service plans. My lawyer from Lawyers for Children used to let me know or tell my social worker to let me know when I had court [hearings]…for every year, for placement.”

Another said that she had the chance to give input at the SPRs: “And we had this meeting to discuss planning for me and I always got a chance to have my input – saying, ‘well, I don’t want to do this, I don’t want to do that. But if we could work on this, maybe I could try this or that’. So…I always got a way of involving what I wanted to say.” A third respondent said that youth need to insist on being involved in their SPRs or staff will leave the young people out of the process:

“See with the kids over there, the staff eat up your brains that if you allow them to make decisions for you, it’s over. They are going to make decisions for you that you don’t want. But it’s also because the pressure they put on you. I mean, literally, the pressure they put on you, you would not want to go to meetings. So this is the thing, if you don’t go to the meetings, they will make a decision for you…If you don’t pick a plan for you, they will pick it for you.
So, they would get these kids so frustrated in a meeting that they would walk out. And when you walk out, they [the agency staff] make the decisions. So I would just sit there and argue back and forth, tit for tat, until I got what I wanted because I knew what was best for me.”

**Self-assertion**

Some respondents discussed the importance of being self-assertive with caseworkers as a way of ensuring that their voices were heard:

“They didn't really give you much [with regard to] decisions. They really didn't allow you to [participate at] a certain point. On the paper, it says you are entitled to make your own decisions and they will help you make your decisions, but to them it’s like…they knew what was best for me. And staff didn't like that part of me because I always knew what I felt was best for me…So, when it came to my decisions, I insisted and insisted and insisted. Cause I knew what I wanted.”

“The only problem, if you really want [services], you have to stay on your counselor. Like keep on reminding them, every day or every other day. ‘Say, remember you have to do this, remember you have [to do that]’…because you still got to remember, she got more than ten people to do paperwork for…So, I be like, ‘if you can't do this, just give me the address and let me go down there and do it myself’. That's mostly what I did. Like, for me to get Section 8, I went down there myself. Public assistance, I went down there myself. I filled out the paperwork and all that. Most of the girls, they rely on [staff] to do everything. And if you really want something done, you try to do it yourself.”

“I think that…you should really be able to talk to your [ACS] worker because children’s rights are really violated a lot in foster care. A lot! There’s a lot of things that really happen…and [residents] feel like they have nowhere to turn to and they don’t know a lot of times that any group home you in, they answer to ACS. And I think that what’s in your file, you should know what’s in your file, what somebody is writing in your file. Because…all of a sudden maybe this ACS worker might decide to show up on one of my team meetings. And all she’s looking at is this bad file and then she places her judgment on me like this and I’m sitting here complaining and…she’s telling me, ‘well this is why you are not getting into this one, why you’re not getting that’. And she doesn’t understand that I wind up doing this because all this time I’m not getting what I’m supposed to get.”

**Other opportunities for involvement**

Three respondents mentioned specific ways in which they became personally involved in efforts to influence the environment at their congregate care facilities. One respondent chaired a group called “Council for Unity” that sponsored meetings for residents in which they could talk about how to better the campus (“We would search for residents, get them and have a talk with them. We were trying to protect them.”); another described participating in a process at the group home in which residents were asked what they would like to do in their classes that year and the group home implemented their ideas; and a third respondent said that she had started a “sisters’ circle” meeting in which the girls and staff would sit together and talk.
TRANSITIONING FROM FOSTER CARE

Respondents expressed a range of feelings about leaving foster care. Several stated that they were eager to leave care. Others, however, expressed more trepidation. One respondent, for example, said:

“I was scared…I was scared to be responsible. Like what happened if I run out of food, what would I do? If I wake up late to go to work? Stuff like, if I lose my job, what am I going to do? If I can't pay for my school? I was just scared of being alone. Nobody around me, being scared. Waking up every morning, getting up and going to work and going to school later on. That scared me, being responsible…”

Most respondents reported that they were discharged to live on their own. One respondent, however, reported being discharged to prison at the age of 20, and another reported having been discharged to a hospital (this respondent commented, “I don't see how they [could] discharge me just like that and just basically to a hospital. A hospital is not a placement.”).

Respondents commented on:

• The extent to which they felt prepared to leave foster care and live on their own
• Their experiences after leaving care

Preparation to transition from care

Respondents were divided in their perceptions of the extent to which they were well prepared to transition from foster care. A number of respondents said that they were well prepared to live on their own:

“So that social worker told me everything I needed to know. What steps to take, where to go. How to do things. How to budget my money…They talk to you about hygiene and stuff like that.”

“We got independent living services. We learned how to open up a bank account, how to budget our money, tutoring. We had a whole bunch of stuff. We went to fairs, community fairs. We went to workshops. We did a lot of interesting things.”

Some respondents focused on their own responsibility for working with the agency to prepare themselves for life on their own. One respondent, for example, said:

“I think [the agency] did good…They’ll help you if you help yourself. And a lot of people are going through the agency like they are going to give me this and they HAVE to…they don't have to do anything. What they do, you got to work with it. That's it. It's just that simple.”
Respondents who expressed satisfaction with their preparation for independent living often focused on the fact that they were encouraged to stay in high school or obtain a GED and that they received strong preparation for work. They highlighted programs that taught them how to conduct themselves on an interview and in a business environment and how to complete a job application. They also focused on programs that provided them with computer and other office and vocational skills—in the words of one respondent, “they're not giving you skills about how to work in McDonald's...all those little crappy jobs.” Other respondents who were satisfied with their independent living programs also pointed to the value of SILPs and training on specific life skills, such as how to do laundry, budget money, open a bank account, grocery shop, and cook.

A number of respondents stated that they were not well prepared to transition from foster care. Among the statements that these respondents made were the following:

“They thought I was prepared, but I don't think I was completely...I felt like they could have prepared me more. Because I was only 20 years old.”

“I wasn't prepared. They gave me that $500 check but you know that goes but so far. I left, I had my driver's license...But I wasn't really prepared. And I think they should have an after-care type of thing, because...you shouldn't leave an agency without having a job, without having a place to live. And basically, they knew I really had nowhere to go.” (This respondent reported that he moved in with his baby's mother, although he did not want to do so, and eventually went to jail).

“I wasn't [prepared], I didn't learn anything as far as independent living from my whole experience in the group home. I tell you the truth – I just started cooking for myself about a month and a half ago.” (This respondent had been out of care for 5 years)

“I was not ready. You know, I had nowhere to live. No money. No family. Nothing...I was down and out after I came out [off] there. I was homeless, bouncing from house to house...I couldn't call nobody. None of my family could help.”

“I felt I wasn't prepared because when I left, it was like...it's not like I was leaving with money, skills. I wasn't leaving with all that...I've been in placements since five [years old] – when I hit eighteen, it was more of a thing of I [was] tired of it. Staff still abusing, acting like kids. I'm really sick of it. I've been in it too long.”

“They [staff] never discussed [how to prepare for the transition from care], while I was in there. They didn't give me time to think it out. They told me the day before it was time for me to be discharged. Once I turned 18, that's when they threw all the pressure at me. Like, 'well, you're going to have to do this and you got to do that and you got to'...OK, I understand that, but the whole time I was up here, you didn't train me for any of this. So you expect me to just go out there and just get everything in one shot. But it's not like that. It takes time.”
Experiences after leaving care
Respondents discussed their experiences after leaving foster care with regard to obtaining health care, housing, and employment; having personal connections with people who could provide support; and having their key papers in their possession.

Health care
Respondents were divided in their experiences regarding access to health care. Five respondents said that they had health insurance and access to health care services after they aged out of care. Among this group, one respondent explained, “They paid for my baby to be born…I had just turned 21, and they let me know they was gonna cut [my Medicaid], but they [said that they would] pay for the baby…[and] so they did. After that, they cut [my Medicaid]. But they don't just cut you off without letting you know how you can achieve this for yourself. They [tell you] what you need to do, who you need to call, what is it that you need to send in to get you some health care.” Another respondent reported having health care insurance through the respondent’s employment with UPS. A third reported receiving health care from the same doctor at the same health clinic that provided services to him when he was in foster care.

Four respondents, however, reported having no health care insurance or just having received coverage:

“I've been out of the system for two years now. Two years and I still don't have a health plan. I finally signed myself up to a health plan. You are supposed to stay with Medicaid after you leave for about 6 months to a year…They cut me off the same day I left. Me and my child.”

“I…left [foster care, and] my insurance was gone. Right now, I don't even have insurance. So if anything happened to me, I'd have to pay.”

“When I [arrived at] the hospital and tried to get some medication, I found out [that] my Medicaid had been cut off with no notice, no nothing. No, 'hey, now that you are no longer in care, your Medicaid will be cut off on this date'. No, I don't get that. I get to go to the emergency room and see if it works.”

“I never had Medicaid. I just got it.”

Housing
Several respondents described their efforts to obtain Section 8 housing, with mixed results:

“[The agency] did help me out as far as Section 8…I was working and got a call one day, my worker said a new program just started where they were helping kids to apply for Section 8…so, when they do age out, they have a better chance of getting an apartment and they still have that help. A little extra help…That was a good thing that came through for me…”

“What happened was when I was about to age out, when I was about to turn 21, I was trying to get Section 8. I was trying to get the people to give me a letter so I could take it to Section 8, so I could get my apartment faster…But it never happened. I was trying to get Section 8 and to this date, I've been waiting for Section 8 housing since 2000.”
“I couldn't apply for Section 8 in time because my foster agency [did not take] care of my immigration problem ahead of time…I [had] to wait for Section 8, which is in the process now…Why not put in the Section 8 application early so that [youth do not end up in]…the next system which will be…a shelter in the city of New York?”

Some respondents reported that staff helped them find a place to live. One stated for example, that the independent living program connected him with a landlord who had an apartment available. Other respondents, however, reported receiving little or no help from staff.

Eight respondents reported that they had been homeless at some point after leaving care. One respondent said that she was discharged with her children, with $68 and no place to live. “I was homeless.” Another, who was living at Covenant House at the time of the interview, said that staff said nothing about housing resources when she was discharged from care. Finally, one respondent reported having signed himself out of care with a $750 stipend. “And I gave it to my brother…he was selling drugs. So I was like, 'I'll give it to him and he could double that easy for me'. He doubled it a couple of times, and then he got locked up about six months ago. And that's when I went to the shelter.”

Employment
Some respondents reported success in finding and maintaining employment and attributed their success, as discussed earlier, to strong job preparation prior to leaving care. Only eight respondents reported that they were employed at the time of the interview. Two stated that they had not worked since leaving foster care. One respondent reported that despite learning “how to go out there and talk…I just never seem to get a job.” Another said that she had had to do “a lot of things to manage.” This respondent reported “stripping a little to basically survive,” but she stated that she had not at any time prostituted.

Personal connections
Some respondents stated that they could always turn to the staff at their group homes after they left care if they needed someone to talk with or needed help. These young adults made the following comments:

“The group home will help us with resources…Not forever but as long as the director doesn't change and the social worker still remembers us…Yeah, I go to visit. I go like every 3-4 months…I keep in contact with them and the group home [has] a reunion every year. So, girls from before me, they come every year. And the home arranges it. They try to keep everybody's address together so they could do it...It's like a family reunion.”

“If I needed anything, I could always go back to the group home. I could always go back to Miss Rita. Even though I don't live there anymore. I could always go back to Miss Rita and say I'm going through this, I'm going through that. I need help. She would help me.”

One respondent, however, reported having no one to turn to as she faced the problems in her life. She said:

“I have no job. I don't have a high school diploma. I don't have a GED. I'm not in school. What else am I going to do in the streets? How am I going to eat when the day comes? Where am I
going to sleep tonight? It’s all these questions that go through your head. You feel like you don’t have a family that you can turn around to and be like I need help or you know you feel like the situation that you are in right now, you just don’t want to deal with it because it’s not going the way you would like.”

Key papers
Two respondents said that they had their key papers when they left care because they had kept the original papers and provided their group homes only with copies. Two others reported being given their birth certificates and Social Security numbers when they left foster care. Another respondent, however, said that the agency refused to provide her with a copy of her records, including medical records that she needed to start school. Similarly, another respondent reported that the agency did not keep or provide her with medical records for her son:

“I couldn’t find my son’s immunization card cause they keep everything. They don’t allow you to keep anything when it comes to your Medicaid, your prescriptions, anything. Everything – they got it for you and they kept in on file. So, when it was time for me to leave, they give me the most skinniest files with like about five or six sheets…My son had to get everything repeated because they didn’t know what he got and what he didn’t…”

II. FINDINGS FROM INTERVIEWS AND FOCUS GROUPS WITH YOUNG ADULTS: WHAT WORKS AND WHAT NEEDS TO BE CHANGED

The young adults who participated in the individual interviews (21 young adults) and in the two focus groups (10 young adults) were asked: (1) what worked for you in congregate care? and (2) what did not work for you and needs to be changed so that foster care can work better for teens in care?

Positive aspects of congregate care
The young adults’ responses to “what worked?” are summarized in the following table.

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<th>Areas that Worked</th>
<th>Specific Aspects</th>
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<td>• Staff to talk to</td>
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<td></td>
<td>• Staff who connected youth with programs</td>
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<td></td>
<td>• Staff who were there “to guide me to the right path”</td>
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<td>• Staff who were there “help me focus in school”</td>
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<td>• Staff who “tried to look out for you”</td>
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<td>Basic needs</td>
<td>• Shelter, not being on the streets</td>
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<td>• Staying with a sibling</td>
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<td>• Being in a single room</td>
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<td>• The “people I lived with”</td>
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Services and opportunities

- Trips to interesting places
- The classes
- Clothing allowance and shopping
- Counseling
- Good programs to prepare youth for a job
- Ability to cook meals
- Help in getting first job
- Financial aid
- Perks when reaching the highest level of the facility

Although the young adults mentioned other positive aspects of their experiences, the most frequently mentioned aspect of young adults’ experiences in congregate care was the staff with whom the young adults had had supportive relationships:

“25% out of 100% were pure and so helpful that they would go out of their way and go on interviews with you to make sure you went and everything [was] okay. And help you with your studies. Staff that were actually there for us to help us become a better person than what our parents had given us. Definitely the staff.”

“The staff used to counsel me as I was their own daughter. Or punish me as I was their own daughter. That stuff really do count. It all depends on love. I think love comes a real long way...As I said before, the kids do better in group homes if there is love in the group home. If they walk in and see a beautiful home and dinner on the table and you can talk to staff about anything without being afraid – those are the kids that do good. If you push them to stay in school, if you talk to them as if they were your own kids – those are what make the kids do better.”

Suggestions for changes in congregate care

The young adults expressed dissatisfaction with many aspects of their experiences in congregate care and suggested several steps that could be taken to improve foster care for youth in care. One young adult summed up what needs to be changed by saying that young people in foster care need to feel that they are part of a family:

“Don’t let the child feel like they’re a foster child. Make them feel like they’re one of your own...Be more open and outspoken. Let them know that they’re a part of everyone else. You’re a family, you’re like one of mine. Make them feel like they wanted. They [are] in foster care for a reason. Because they don’t have nobody.”

Specifically, the young adults identified the following issues and made the following suggestions:

<table>
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<tr>
<th>Areas Needing Improvement</th>
<th>Specific Suggestions</th>
</tr>
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| The staffing at congregate care facilities | • Have more staff so that a young person has many staff members available to him.  
• Improve staff at congregate care facilities, including instituting background checks and other screening. |
| **The staffing at congregate care facilities** (cont.) | • Ensure that staff who are hired care about youth.  
• Require group care staff to first live in a group home as residents as part of their training.  
• Train staff on how to work with youth.  
• Hire more professional staff for group homes.  
• Hire people who themselves have been in a group home.  
• Address the homophobia of staff.  
• Have staff get more involved with youth.  
• Drug test staff. |
| **The conditions at congregate care facilities** | • Provide better food and better beds.  
• Make group homes more “family-like” (such as by taking the locks off the refrigerators). |
| **Placement practices** | • Keep family members together.  
• Do not place 11-year-olds and 18-year-olds together. |
| **Educational services for youth in congregate care** | • Force the residents to go to school or participate in a program.  
• Structure classrooms so that students have more individual attention. |
| **Mental health services for youth in care** | • In the words of one young adult:  
*“Put a little spice into your therapy sessions…Maybe [therapists] need some cultural lessons to go with those degrees. Because [a diploma] is a good thing to put on your wall. but if you truly want to help, you must understand your clients.”*  
• Stop giving youth medication when there is nothing wrong with them.  
• Provide more one-on-one counseling for youth who need attention.  
• Provide more emotional support. |
| **Safety** | • Enforce rules to ensure safety.  
• Address the issue of stealing.  
• Do not allow facilities to “lock out” youth for curfew violations.  
• Make curfews stricter, particularly for younger youth, and base curfews on age, not as a reward for good behavior.  
• Stop using the police when someone does “something bad in the stupid group home” (“It just makes it worse.”) |
| Safety (cont.) | • Do not allow staff to use residents against one another.  
|               | • Prohibit staff from stealing from residents. |
| Youth involvement | • Interview young people about their goals at the time that they enter group care.  
|                  | • Communicate with the youth about their own situations.  
|                  | • Let youth make their own decisions. |
| Mentoring | • Involve young adults who have aged out of care with youth currently in care.  
|           | • Develop mentoring programs for youth in care. |
| Preparation for independent living | • Ensure that everyone leaves foster care “at least with some type of training,” and a high school diploma or GED.  
|                                   | • Ensure that everyone leaves foster care with a job.  
|                                   | • Do not discharge youth to homelessness.  
|                                   | • Make sure that all youth receive their discharge grants. |
| Aftercare | • Provide aftercare services.  
|           | • Provide more extensive services over a longer period of time.  
|           | • Offer aftercare services for youth who have left care, including “reunions” at group care facilities.  
|           | • Develop outreach services as a part of aftercare with a focus on personal connections with youth.  
|           | • Have staff remain in contact with youth in college. |
| ACS and the private agencies | • Create a more active role for ACS in responding to youth.  
|                             | • Improve communication among ACS, the private agencies, the education department, and the lawyers so that they work more effectively together. |
In addition to empirical research that sought the views and perspectives of a range of stakeholders, the study sought information from the Administration for Children's Services (ACS). Information was sought in an effort to capture, from ACS' perspective, the systemic and budget environment in which the findings from the study might be best understood. In this section, the information obtained from ACS is summarized, and the budgetary environment for child welfare services in New York City is described.

THE ACS PERSPECTIVE ON ISSUES AFFECTING YOUTH IN CONGREGATE CARE

Information was sought from ACS regarding its activities and efforts with regard to the six areas on which this study focused – placements for youth in foster care, with a focus on the current reliance on congregate care; services for youth in congregate care; safety issues in congregate care settings; permanency for youth in congregate care; the transitioning of youth from foster care; and youth involvement in planning and decision-making. Information also was sought regarding the agency's assessment of what is working well for youth in care and the issues which require greater attention in each of these areas.

**Placements for youth in care**

ACS acknowledged that placement options for youth in foster care are limited. To that end, the agency identified several strategies that it is implementing in an attempt to address this issue: efforts to reduce the number of congregate care beds; efforts to recruit “regular” and therapeutic foster families; the development and implementation of Circle of Support groups to recruit and retain foster and adoptive parents; a research-driven advertising campaign to encourage potential foster parents to open their homes to teens; a youth speakers’ bureau; expansion of placement resources for GLBTQ youth; and strengthening of staff at ACS direct-care congregate care facilities. ACS also identified several challenges regarding ensuring that there are appropriate placements for youth in care:

**ACS must serve many youth who would be served more properly by other systems.** ACS stated that it may not reject a child for placement because of the nature of the child's needs although private child welfare agencies may do so (making “therapeutic objections” if they believe they cannot meet a particular child's needs). ACS stated that the children most in need of specialized services, as a result, tend to be placed in ACS direct-care facilities. The agency also noted that many children with severe needs who would be better served in mental health and other settings (such as through the Office of Mental Retardation and Developmental Disabilities) are currently in ACS congregate care facilities. The agency stated that it cannot effectively meet the needs of these children and that they drain resources that could be used to serve the population that ACS can effectively serve. ACS also reported that about ten percent of youth in congregate care are brought into care under Article III (delinquency); that some private agencies do not accept youth with a delinquency docket; and that ACS must either find an agency that will accept youth with that background or place the youth in one of its own direct-care facilities.

**Most residential treatment centers are outside of New York City, making it difficult to involve families in permanency planning and visiting.** ACS reported that approximately half of all youngsters in residential treatment centers are on large campus settings outside of the City. Viewing this situation as problematic and contrary to the agency's overall approach of keeping children near their families in order to strengthen family bonds, ACS stated that it is seeking to reduce the number of out-of-city placements.
High staff turnover in congregate care facilities undermines the quality of placements. The Agency Program Assistance (APA) unit of ACS monitors contract agencies and evaluates their performance by inspecting, grading, and sending out corrective action plans when agencies have not followed proper policy or procedure. Based on the work of the APA, ACS reported that the greatest challenge for private agencies is the low number of child care staff and high turnover rates. ACS, however, did not report how the APA addresses these issues with private agencies (although it stated that in its own direct-care facilities, staff-to-resident ratios have improved with a current ratio of 1:7). ACS identified four issues that contribute to high staff turnover in private agencies: (1) low salaries (interestingly, the starting salary for child welfare specialists who work in ACS's direct-care facilities is $27,000 (and $41,000 for supervisors) with benefits while child welfare specialists who work for contract agencies are typically paid between $18,000 and $22,000 a year); (2) work-related stress; (3) inadequate training (staff in direct-care facilities, as opposed to the staff of private agencies, were reported as having significant levels of training); and (4) poor supervision.

Services for youth in congregate care
By way of general observation, ACS stated that service systems should come together in an integrated way to meet the unique needs of youth and that families should be engaged in all aspects of teens’ care. ACS indicated that private agencies with which it contracts vary with regard to the services that they provide, although it did not make clear how these differences were documented or taken into account when determining placement resources for youth. ACS principally highlighted the services that it provides to GLBTQ youth and stated that the Lambda Legal Defense Fund's report on GLBTQ youth in care found that New York City is a national leader in providing services to this population. With regard to services for teen mothers, ACS highlighted its voluntary program called TASA that provides services to pregnant and parenting teens and their families in order to prevent youth from coming into care.

ACS also addressed some of the frequently identified service needs of youth in care: education, health care services, substance abuse treatment services, and mental health services.

Education. ACS focused heavily on its educational initiative in collaboration with the Independent Living Consortium that has addressed some of the “key educational issues facing youth in care,” although it did not specify these issues. It further reported that it is advocating for a liaison in every educational superintendent's office who will be assigned to work on issues affecting children in foster care. ACS identified several major challenges with regard to educational services for youth in care who are in high school: attendance, consistency in the quality of education, and transition to other education programs (particularly vocational training and college). It identified other educational issues of concern for youth: difficulties in transferring youth to other schools and re-enrollment; the transition of youth from out-of-State to in-City schools; and, in some cases, the determination that children need “special education” when they do not have special needs. ACS did not specify the efforts it is undertaking to address these issues. It noted, however, that it faces budgetary issues regarding educational services because it is required to pay for educational placements within the State for children with special needs and must pay for education for certain out-of-State youth as well.
**Health care services.** ACS reported that reforming medical care provision for children in foster care has been a key initiative of ACS and that progress has been made in establishing standards and mechanisms to ensure quality medical care for youth in direct-care facilities and at private agencies. ACS, however, listed several concerns with regard to physical health: (1) agency-based variations in the quality of and degree to which youth receive the required medical services; (2) difficulty recruiting and retaining nursing staff to provide medical care management; (3) inadequately resourced dental care and shortage of dental care services; and (4) inadequate training of child welfare staff regarding the medical problems of children and youth. ACS also noted as a further challenge that it and its contract foster care agencies must rely on systems over which they do not have regulatory control, such as the hospital system. It also pointed to the problems created by the current medical care financing system (discussed later in this section).

**Substance abuse treatment services.** ACS reported that currently there are no State standards regarding the foster care system's responsibilities for addressing substance abuse issues for children in foster care. ACS reported that it has funded and developed a comprehensive set of substance abuse standards for congregate care programs, including standards related to substance abuse screening, assessment, prevention, referral to treatment, and follow-up services. ACS further stated that although it has managed to continue the funding for these services to youth in foster care, it faces potential elimination of such services after September 2003. ACS acknowledged that there are insufficient adolescent treatment services in the substance abuse service system operated by the New York State Office of Alcoholism and Substance Abuse Services (OASAS), but stated that the OASAS system is the sole system allowed to provide these treatment services. ACS stated that State policy changes and financing of substance abuse services through Medicaid per diems are needed to ensure continuity of services and to afford opportunities for better integration of substance abuse services with other services to youth in foster care settings.

**Mental health services.** ACS reported that four years ago, it adopted a policy of universal screening for mental health (and developmental) issues for all children coming into foster care and made mental health (and developmental) screening, assessment, and follow-up interventions a part of ACS's foster care practice and contractual requirements. ACS stated that this policy was designed to ensure that the mental health problems of children and youth in foster care are timely identified and addressed. ACS stated, however, that there are very limited mental health services in New York City; best practice standards for mental health are not as well established as are medical practice standards; there are problems related to youth's compliance with mental health appointments; and there is high clinician turnover. ACS reported that it has a number of initiatives designed to address the shortage of quality mental health services for youth. ACS stated that it is collaborating with the Office of Mental Health to expand the range of community-based and residential service options; implementing a pilot program to enroll children and youth in foster care in the Office of Mental Health's Home and Community Based Services Waiver programs; developing Cooperating Mental Health Provider networks; improving linkages with Coordinated Children's Services Initiative networks; developing a partnership with Bellevue Hospital to assess children with mental health problems and use those assessments to inform placement decisions and ensure adequate clinical monitoring when youth come into care already on psychotropic medications; developing cross-systems protocols and training opportunities; and implementing trauma trainings for caregivers and child welfare staff.
Safety in congregate care facilities
With regard to safety issues in congregate care facilities, ACS noted that it seeks to monitor the level of complaints about safety issues, and the agency reported that it “would like to be able to feed data into the information that it maintains on each agency about safety and the level of complaints.” ACS reported that it has established a task force on AWOL issues but that efforts were in the early stages of development.

Permanency for youth in congregate care
ACS reported that it has placed a strong focus on permanency for adolescents but that it faces a challenge in convincing the private child welfare agencies with which it contracts that youth need the same sense of permanency as young children and that the emphasis should not be solely on increasing services to youth in congregate care. ACS reported that it has retained outside experts to assist private agencies in making the paradigm shift to focus on permanency for teens. ACS also described its focus on adoption as an option for adolescents and reported that an outside consultant is working with ACS and private agencies to clarify the reasons why teens so often say “no” to adoption. ACS stated that one key challenge is the New York State law that requires that teens ages 14 and older consent to their adoptions. ACS stated that there is a historical belief that at age 14, a youth should be assigned a goal of 03 (independent living) and consequently, “that goal is just being checked off” with no compelling reason for the goal and no other plan considered. As described earlier in this report, ACS issued a new policy (effective July 1, 2003) that requires dual track plans to ensure permanency for youth in care. ACS stated that implementation of this policy primarily involves a shift in thinking and “different work, not more work” for the agencies – listening to youth, contacting the people they identify as resources, and actively engaging youth in the process of building these relationships.

Youth involvement
ACS reported that youth development is a “top goal” for ACS. It described its youth development philosophy as a commitment to young people that involves paying more attention so that youth are not required to go through “all the transitions and changes we put them through” and talking with young people to find out what services they need before they are placed into foster care. ACS stated that its youth development focus is based on several principles: youth have a role to play (that is, society should value them and give them opportunities); youth should be able to make decisions or have input on issues that affect them (such as curfews); intersystem collaboration and connections are essential; and when youth are ready to leave foster care, there should be a safety net – that is, each youth should have someone to help steer him or her in the right direction. ACS stated that bringing youth development to group facilities will require more resources, better paid staff, and models of good practice. It identified several challenges to integrating a youth development focus: the history of child welfare; who the children and youth are (they often are not viewed as having potential); staff training; accountability; and developing incentives for caseworkers to make the shift to youth development. ACS reported that it is using a number of strategies to institute youth development: it is “starting at the top” – that is, at ACS (noting that “ACS should be a powerhouse, showing ‘this is the way it has to get done’”); it is focusing on developing best practice standards that private agencies will be expected to meet; and it is implementing an Adolescent Service Plan Steering Committee to guide the planning process which will include young people.
Transition from foster care
ACS reported that little data are available on the outcomes for youth who leave foster care. It did comment, however, on housing resources and educational opportunities for youth leaving care and referenced its mentoring program.

Housing. ACS highlighted the lack of housing for youth transitioning from care. It stated that the SILP program (described earlier in this report) is a strong program, but there are too few SILP beds. ACS further noted that there is not a seamless service referral mechanism to SILPS, and there may be an issue with the selection process. ACS noted that private agencies want to have stable group homes and, as a result, may not refer youth who can succeed in a SILP because these youth are the mature and stable youth in group homes.

ACS reported that it works to obtain Section 8 housing for youth with goals of independent living. The agency stated that independent living liaisons are trained “ad nauseum” and given lists of apartment postings; there is a database of realtors who accept Section 8 vouchers; and ACS maintains lists of available apartments identified from newspaper advertisements. ACS noted, however, that once a youth obtains a voucher, there may not be housing resources that will accept a voucher. ACS reported that nationally, a third of all Section 8 vouchers are refunded for lack of housing options but that New York City achieves a higher rate. ACS noted that youth with permanency goals other than independent living do not have the same priority for Section 8 housing but stated that as of August 2002, a priority code for Section 8 housing is given to families who have a child in foster care or a child at risk of coming into care.

Education. With regard to the educational needs of youth transitioning from foster care, ACS reported that it has developed a peer leadership program in which youth are trained to be advocates and lobby for state college tuition reductions for youth in foster care. ACS also described its college support program in which college-age youth are provided with financial assistance, computers, and Staples cards. ACS reported that it has found that youth in college often need personal connections more than the material incentives that the program provides, and that, as a result, their program now focuses on such intangibles as personal support systems and peer support groups. ACS stated that a recent survey indicated that 500 foster youth were enrolled in college, but it could not provide data on college outcomes.

Mentoring. ACS reported that it has a program of volunteer mentors who make a one-year minimum commitment and establish one-on-one relationships with youth in foster care. It further stated that it works closely with several mentoring organizations in New York City, such as the Mentoring Partnership of New York, Mentoring USA, and Big Brothers Big Sisters, to identify mentoring opportunities for young people.

THE BUDGETARY ENVIRONMENT
A key aspect of the environment for child welfare services in New York City is the level of funding available to ACS and the private child welfare agencies that serve youth in care. The following describes the funding mechanisms for the City’s child welfare system and the current budget environment.
An overview of child welfare funding in New York City

Funding for child welfare services in New York City is a complex arrangement, combining federal, state, and local dollars. Titles IV-B and IV-E of the Social Security Act provide the bulk of federal funding for the New York State child welfare system and, by extension, the New York City system. Under Title IV-E, the federal government pays New York State 50% of the board and maintenance costs for children in foster care who are eligible for federally-funded foster care services (U.S. House of Representatives, 2000). Title IV-B provides funding for services for children, youth, and families served by the child welfare system (U.S. House of Representatives, 2000). In addition, the John H. Chaffee Foster Care Independence Program provides federal funding for programs aimed at supporting youth’s transitions from foster care to self-sufficiency. Under the Chaffee Program, 20% of the program costs must be met with non-federal matching funds (U.S. House of Representatives, 2000).

At the state level, the New York State Office of Children and Family Services (OCFS) funds the New York City child welfare service program (as it does other local child welfare programs in the State) through the Family and Children’s Services Block Grant. The Block Grant allocates a capped level of funding to each locality for all preventive and protective child welfare services and most foster care services, including daily room and board payments for youth in congregate care facilities (Citizens’ Committee for Children, 1998). Critics have argued that the way in which Block Grant funds are allocated discriminates against New York City. They point out that the amount of the Block Grant allocated to the City is inadequate because, although New York City provides services to approximately 81% of the State’s foster care population and has a significantly higher child poverty rate than the rest of the State, it only receives 65% of the Block Grant (Citizens’ Committee for Children, 1998).

A second aspect of the State funding system that has an impact on the New York City child welfare system is that it is OCFS (not ACS) that calculates the Maximum State Aid Rates (MSARs) – that is, the maximum reimbursement rates that the State allows localities to pay private agencies for foster care services. Private agencies are required to report their expenditure histories to OCFS for the last two years. OCFS then calculates the MSAR for each individual agency. As a result, agencies receive different rates based on different expenditure histories. Although OCFS sets the MSARs, it is ACS that is responsible for contracting with and paying private agencies for foster care services and which ultimately must decide the percentage of the MSAR to pass through to private agencies. ACS establishes, on an industry-wide basis, the percentage of the MSAR that ACS will pay. Private agencies do not typically receive 100% of their OCFS-determined MSAR but some percentage of that rate – a percentage that is applied to all private child welfare agencies in the City (Citizens’ Committee for Children, 1998). The MSAR calculation has a differential impact. Agencies with substantial private endowments are able to use private dollars to increase their spending and, therefore, their MSARs in later years. By contrast, agencies without significant private funding are unable to increase their spending and ultimately qualify for higher MSARs.

A third aspect of state funding that affects services for children and youth in foster care is the Medicaid per diem. Medicaid covers all children and youth in foster care in New York City (whether they are in the direct care of ACS or they are under the care of a private child welfare agency that has contracted with ACS). Each agency receives a Medicaid per diem payment for each child in foster care in its care. The amount of the Medicaid per diem, however, varies among agencies. Agencies must incur expenses for two years before
they begin to be reimbursed for those expenses. Consequently, although any Medicaid-reimbursable service can be covered by an agency’s Medicaid per diem, an agency – depending on its historical pattern of service delivery and level of payment – may deem certain services to be beyond the scope of its per diem. An agency that lacks funds to invest in services so that its per diem can be increased in the future may adopt a more restrictive payment policy for certain expenses (that is, it may make the decision that the service is not to be paid through the per diem) and may opt, instead, to rely more heavily on community-based services, for which agencies must compete.

An added complexity is that the current State financing system allows some expenses to be reimbursed through the Medicaid per diem and others to be reimbursed through fee-for-service Medicaid. An agency’s payment history determines how the expenditures will be allocated between the two payment systems. This feature of the financing system causes tremendous variations among agencies. It also introduces a degree of confusion among caseworkers regarding the services for which their agencies will pay. Consultation with agency fiscal departments is often necessary when making service arrangements.

In addition to federal and state funding for child welfare services, city tax revenues provide significant funding for foster care services, including congregate care. City tax revenues provide ACS with funding to contract with private agencies to provide services over and above the foster care maintenance payments that are funded with a mix of federal and state funds (Citizens’ Committee for Children, 1998).

**Current budgetary issues affecting child welfare services in New York City**

This study sought from ACS information on the impact of the current funding mechanisms on child welfare services in New York City and the impact of the budget reductions that recently have affected all City services, including child welfare services (see Citizens’ Coalition for Children, 2003). ACS reported that foster care services, including congregate care services, have been significantly affected by the Fiscal Year 2004 budget reductions and that ACS, consequently, faces significant financial challenges. ACS stated that between FY 2001 and FY 2004, the ACS budget for foster care services will have been reduced by a total of $240,000,000.

ACS noted that the current fiscal situation is the result of both a decreasing level of resources and the mechanics of the current funding system. As a result of the State’s system of setting a MSAR for each individual child welfare agency, the City currently has 228 different foster care rates. In Fiscal Year 2003, ACS was not able to cover the full cost of care as set by the MSARs (that is, ACS was not able to pay agencies at rates reflecting 100% of the MSAR determined for each agency). When information for this study was initially gathered in early 2003, ACS reported that it may have to reduce rates to private agencies effective July 1, 2003. At that time, it was believed that foster home boarding rates (which range from $18 to $36 per day) might have to be reduced by 5.1%, and congregate care rates reduced by 3.1%. In mid-2003, however, ACS reported that the City had provided ACS with $8.9 million to postpone the implementation of the anticipated rate reduction until January 1, 2004, conditional upon ACS increasing its federal revenues for foster care by an equal amount.
ACS also discussed the impact of the Medicaid per diem system on mental health and substance abuse services. The agency reported that when the foster care system has consistently conducted mental health screenings and assessments, there has been a higher rate of identification of mental health problems, and a determination that larger numbers of children and youth need mental health services. ACS noted that, given this reality, allocations in Medicaid per diems for mental health services most likely reflect a resource need that is under-estimated. ACS also pointed out that because the State has not required substance abuse screening, assessment, and prevention services as part of its foster care standards, few agencies have incurred costs for such services, and as a result, the Medicaid per diem rates for most agencies do not include an allocation for substance abuse services. In order to improve medical, mental health, and substance abuse services for children and youth in foster care, ACS stated that the State needs to reform the financing and payment systems to agencies to be more rational, equitable, and needs-based.

**DISCUSSION AND RECOMMENDATIONS**

The professionals and young adults who were interviewed for this study demonstrated a remarkable level of agreement on a range of issues that impact youth placed in congregate care settings. At the same time, there were some interesting differences in their perspectives on certain topics. This section of the report discusses the findings from the interviews with professionals and young adults and the information provided by ACS and advances recommendations for improving the experiences of youth in foster care.

**DISCUSSION OF FINDINGS**

The study resulted in key findings on the six issues on which the research focused: (1) congregate care as a placement option for youth in foster care; (2) the services needed by and provided to youth in congregate care; (3) the safety of congregate care settings; (4) permanency planning and outcomes for youth in congregate care; (5) youth's transitions from foster care; and (6) youth involvement in planning and decision-making.

Although professionals and young adults recognized the benefits of some congregate care placements for certain youth, they generally did not view congregate care as an appropriate option for most youth in care. Both groups saw congregate care as a placement option that often fails to meet the needs of youth and, in too many instances, affirmatively harms young people. Both professionals and young adults stated that congregate care environments do not provide “home-like” environments; are geographically distant from youth's families, friends, schools, and communities, thereby working against the maintenance of important family and personal connections; do not offer needed services; and are staffed by individuals who do not or cannot respond appropriately to the needs of young people placed in those facilities.

At the same time, both groups expressed a recognition that some level of congregate care will always be needed, even if a broader range of family-based placements were developed for youth in care. Both professionals and young adults, however, expressed concerns about the extreme variability in the quality of current congregate care placements – ranging from “good” to “atrocious” facilities. A key issue for both groups with regard to the quality of congregate care was the quality of staff in group and residential care.
facilities. Professionals repeatedly noted problems related to staff screening, staff credentials, staff training, and supervision. Young adults frequently mentioned the negative attitudes of staff and their lack of receptivity to youth's needs. Interestingly, some young adults reported that they had been placed in facilities that were staffed by caring adults and that felt like “home,” revealing that the very characteristics that most respondents found lacking in congregate care can indeed be created and sustained in group and residential care facilities.

With regard to services, there was agreement among both professionals and young adults that, in general, services for youth in congregate care often were not available, were not provided based on youth's individual needs, and were of extremely variable quality. Of particular concern to both young adults and professionals was the poor quality of educational and mental health services. Educationally, serious issues were identified in connection with placements in both residential treatment centers and group care facilities. Both groups stated that in RTCs, youth typically are placed in on-campus schools that generally offer only special education programs (even for youth who have no special educational needs) and youth of all ages are grouped together. Young adults expressed frustration that RTCs would not enroll them in public schools where there were academic and social opportunities. Young adults and professionals stated that in group homes, staff do not work to ensure that youth are enrolled in public schools or that youth attend school. The comments of both professionals and young adults about the educational deficits of youth who age out of care without either a high school diploma or GED accentuated the impact of the poor quality of educational services while youth are in care.

In the area of mental health services, professionals noted the lack of quality mental health services for youth, the absence of any standards for mental health services and inadequate funding for these services. Young adults focused on their experiences with therapists who did not appear to understand the issues confronting youth in care and who seemed more focused on assessment than on actually counseling youth. Interestingly, youth who reported good experiences with regard to counseling and emotional support attributed the benefits that they had received to social workers and other group home staff. These observations again emphasize that quality staffing is indeed possible and when quality staff are on site, they can provide youth with the emotional support and assistance that they need.

In the health care arena, professionals and young adults had somewhat different perspectives. Professionals generally rated health care services for youth in care as good, with only a few respondents focusing on family planning services. Young adults, on the other hand, often mentioned the need for access to condoms and other forms of birth control and reported variable responses from their facilities. Of particular note were their comments on pregnancy and abortion and the fact that three young adults reported that young women become pregnant while in care “from guys on campus.” These observations again raise staffing issues, suggesting the absence of supervision and control in many group and residential care environments.

Most professionals and virtually all young adults reported that safety is a significant concern in congregate care environments. Both professionals and young adults stated that safety issues arose in connection with peer-on-peer violence, stealing of youth's personal belongings (which was reported to be pervasive), inappropriate staff conduct, the poor physical conditions of facilities, and the neighborhoods in which some facilities are located. The young adults, however, provided far more graphic information about the nature
and scope of safety problems, making clear that highly dangerous situations arise in congregate care facilities, including the presence of weapons on-site, staff instigation of resident fighting, gang activity, staff violence toward and verbal abuse of youth, staff drug use on site, and staff's sexual relationships with residents. Young adults also detailed a range of abuses associated with staff's inappropriate and excessive use of restraint and isolation. In addition, young adults reported troubling incidents in which youth who missed curfew were locked out of facilities and left on the street overnight. Both professionals and young adults focused on the role of staff in ensuring safety. Young adults who reported not feeling safe described staff as “going crazy,” “just overlooking things,” and letting “you know off the bat that they’re there for the check.” Young adults who reported feeling safe at their facilities said that it was staff who gave them a sense of security – making clear that it is indeed possible for staff to effectively maintain control and protect youth in congregate care facilities.

Professionals and young adults addressed the quality of permanency planning for youth in care but emphasized somewhat different issues. Professionals were critical of the quality of permanency planning overall, identifying a number of systemic factors that undermine quality work in this area. They focused on the location of many facilities outside of New York City which makes work with families difficult, the belief that family is not important to teens, and facilities' focus on operational issues instead of permanency. Both professionals and young adults discussed issues regarding reunification and family connections but, interestingly, not a single young adult reported actually being reunified with family even when reunification was the assigned permanency goal. Young adults highlighted the need for connections that included family but also other important people in their lives, including foster families. Professionals were particularly focused on the issues surrounding the appropriateness of adoption versus independent living as a permanency goal for youth and offered a wide range of perspectives. The young adults focused more on their desires regarding permanency, with many reporting that they simply wanted “to be independent.” In several cases, young adults indicated, however, that other options were not fully explored with them.

Both professionals and young adults (most of whom had aged out of foster care to live independently) stated concerns about the quality of independent living preparation. Professionals were concerned that too much of the “preparation” focuses on classroom instruction unconnected with the real challenges that youth face after discharge from care. They endorsed SILPs as a strong model for preparation of youth for “real life.” The young adults varied somewhat in their assessments of their own independent living preparation. Although some stated that they were ready to leave care (principally youth who had been encouraged to obtain a high school diploma or GED and job training), many young adults stated that they were not ready to be on their own. Many commented on the failure of staff to begin preparing youth sufficiently in advance of their discharge dates.

Both young adults and professionals discussed negative outcomes for youth who leave care with regard to health care, housing, employment, and personal connections. The young adults reported far more problems with health care coverage than professionals generally acknowledged. It was clear, however, that both groups viewed housing as a serious issue for youth who leave care. Problems were attributed to both limited housing resources and to staff not focusing on this issue in a timely and helpful way. Eight of the 21 young adults reported being homeless at some point after leaving care. Young adults also reported being without employment, which both they and professionals attributed to poor educational and work
preparation services prior to discharge. Both groups also focused on the importance of personal connections after youth leave care. Interestingly, a few young adults stated that they turned to the staff at their group homes for help after they left care. This finding, like others, demonstrates that there are successful staffing models that provide youth with family-like connections.

With regard to youth involvement in planning and decision-making, professionals and young adults generally agreed that youth are not actively involved in planning for themselves nor are they typically given opportunities to influence their living environments while in care. Professionals said that youth's wishes about their placements and where they will live upon leaving care generally were not honored; youth's opportunities to participate in Service Plan Reviews (SPRs) were limited; and youth's voices were not sufficiently heard in court proceedings on their cases. Young adults also reported that their preferences regarding their placements and their desires regarding their permanency plans typically were not heard or honored. They reported, however, mixed experiences regarding participation in their SPRs. Young adults placed strong emphasis on the need for youth to assert themselves to ensure that they were included in SPRs, received the services they needed, and influenced the quality of their congregate care environments.

In addition to interviews with young adults and professionals, the study sought information from ACS about its efforts to address the needs of youth in foster care. ACS reported a range of initiatives designed to address many of the issues that were identified by the individuals interviewed in this study. ACS highlighted its expansion of services to GLBTQ youth, its efforts to address the educational issues that youth in foster care face, its work to expand mental health services for youth in care, its Section 8 housing voucher program for youth, its mentoring efforts, and its focus on youth development. Interestingly, those interviewed in this study rarely referenced these efforts (with the exception of the Section 8 housing voucher program), suggesting that information about these initiatives generally has not reached those most involved in serving youth nor the young people themselves.

Both professionals and young adults discussed what they believed is working well for youth in foster care and what needs to be changed to improve the experiences of youth in foster care. The following recommendations are based on both the findings from the study as discussed here and the respondents' suggestions for changes that are needed in the New York City foster care system. These recommendations are advanced with an appreciation of the budget complexities and constraints described earlier in this report. The level of resources for child welfare services in New York City has been significantly affected by the system under which the Family and Children's Services Block Grant is allocated, the process for determining and allocating to private agencies only a portion of the MSAR that is set for that agency, and recent reductions in the budgets for all City agencies. Many of the recommendations set forth, however, do not require additional resources. For the recommendations which do require funding, resources can be mobilized through the strategic use of dollars saved through a reduction in the use of congregate care placements, maximizing funding through Titles IV-B and IV-E of the Social Security Act, and other approaches.
RECOMMENDATIONS

The findings from this study demonstrate that action must be taken in three major areas:

1) Emphasis must be placed on significantly reducing reliance on congregate care for youth in the New York City foster care system, and focus must be placed instead on the development and use of family-based placements for youth in care.

2) To the extent that congregate care is used as a placement resource for youth, it must be substantially transformed – that is, the current group residence model with its focus on behavior control must be replaced with a service-based, family-like model that ensures the safety and well-being of youth.

3) ACS must exert significantly greater control over the provision of congregate care and hold both itself and the private agencies that provide congregate care fully accountable for the outcomes that are – and are not – achieved.

Recommendation #1:
Reduce reliance on congregate care and develop family-based placements for youth in foster care.

Although, as noted above, some young adults and professionals expressed satisfaction with congregate care as a placement resource for youth in foster care, most did not. Young adults often stated that group and residential care facilities were not “like home,” services were poor, staff often were indifferent or hostile, and the facilities were dirty and in some cases dangerous. Professionals who were critical of congregate care variously described it as “a dumping ground,” “a warehouse,” and “a failure.” They expressed serious concerns about the impact of group care environments on the physical, emotional and social well-being of youth. In addition, both young adults and professionals noted that many congregate care facilities are located outside of New York City – far from the youth’s families, communities, friends, and schools. As a result, youth often have difficulty maintaining contact with their families, which significantly impacts reunification and family connection efforts. They also must change schools and either enroll in on-campus schools at RTCs (which were reported to be special education programs for the most part) or wait to be enrolled in a new public school (sometimes for months).

ACS has initiated efforts to reduce its reliance on congregate care and develop foster family resources for youth in care. Its Congregate Care Reduction Initiative – which is being implemented with the assistance of The Annie E. Casey Foundation – involves an analysis of the types of congregate care and/or specific programs that can be reduced or eliminated and the implementation of pilot projects to test out strategies to close a limited number of programs. ACS also has implemented an advertising campaign in an effort to recruit greater numbers of foster families for teens in care. These efforts are entirely consistent with this recommendation and are initial steps in achieving this goal. A higher degree of urgency, however, must be accorded to this issue, and more comprehensive efforts must be made to ensure that youth, with few exceptions, are placed with families when they enter foster care and that they remain with foster families throughout their stays in care. To that end, the following specific steps must be taken:
1) Recruitment must focus on identifying families who want to care for teens, who enjoy working with teens, and who have experience parenting teens. Targeted recruitment to enhance the pool of foster parents for youth is critical. ACS has begun implementation of this effort, but to maximize the outcomes, it is recommended that ACS contract with a number of private agencies with expertise in working with youth to focus exclusively on the recruitment of foster families for young people. Youth currently and formerly in foster care should be involved as consultants in developing and evaluating all recruitment efforts.

Equally important in expanding family resources for youth in care is the implementation of a consistent practice of asking youth when they enter care about relatives and other caring adults in their lives who might serve as foster parents for them. In addition, when a youth's placement must change, youth should be asked for the names of adults with whom they have a good relationship who might serve as foster parents. Caseworkers’ engagement of youth in identifying appropriate placement resources (which may require specific casework training) is essential to enhancing the family resources that are available for youth and to actively involving youth in decisions that affect their current and future status. It is an approach that has proven to be effective in achieving both goals, as exemplified by the You Gotta Believe! program in Brooklyn, New York, with which ACS currently contracts.

Both local and national models for foster parent recruitment exist:

In New York City, the foster care program of the Center for Family Life focuses on keeping children and youth who must enter foster care with foster families who live in their own community of Sunset Park, Brooklyn and emphasizes partnerships between birth parents and foster parents. Family and community connections are sustained; foster families serve as resources for children and their birth families during and after foster care placement; children and youth continue in their same schools; and needed services are mobilized in the community.

Good Shepherd Services has developed a strong foster care program for adolescents, ensuring family placements for youth and services to meet each young person's educational, social, medical, and developmental needs. The program focuses on reunification and reconciliation and when those options are not available, on ensuring permanent families for youth through adoption.

At the national level, the Annie E. Casey Foundation’s Family-to-Family Initiative provides information, tools and resources that can be used to involve communities, leaders and organizations in recruiting and supporting foster families who live in the neighborhoods of the children and youth placed in foster care, with the goal of placing children and youth with families within their own neighborhoods whenever possible instead of placing them in congregate care (The Annie E. Casey Foundation, 2003b).
Casey Family Programs (CFP) (www.casey.org) has developed a series of publications that describe proven strategies for foster parent recruitment, including targeted recruitment for families to foster youth. CFP publications include: *A Community Outreach Handbook for Recruiting Foster Parents and Volunteers*, *Lighting the Way: Attracting and Supporting Foster Families, and Partners: Working with the Business Community to Recruit Foster Parents*. CFP also has developed specialized recruitment tools, *African American Recruitment* and *Latino Foster Family Recruitment*, as well as tools that have been developed through their Breakthrough Series Collaborative on Recruiting and Retaining Resources Families.

2) **Foster families with whom youth are placed must be provided with enhanced financial and service supports.** Foster families who care for teens face a range of challenges that younger children in their care do not present. The foster care board rate must reflect the demands that are placed on foster parents who care for youth. Services – including mental health services, sexual health and reproductive health care services, educational services, recreational services, and respite care – also must be made readily available to support foster parents and enhance the stability and success of youth’s placements.

A proposal to further enhance board rates for foster parents who care for youth may appear, at first glance, to be financially unrealistic. When compared to the cost of group and residential care (which studies have shown to be between three and seven times more expensive than family foster care – see North American Council on Adoptable Children, 2001), however, this alternative represents overall cost savings to a foster care system. At the same time, the costs of an enhanced service package must be weighed against the costs associated with placement disruption and subsequent placements of youth in higher-levels of care. The costs of these services (much of which can be captured under Medicaid, the federal Title IV-B program, and other programs) are, in comparison, small.

3) **Practice must be changed so that caseworkers recognize the value of family for youth.** This study indicated that there are deeply held assumptions among professionals that youth do not “want” families and always prefer a group care setting – assumptions that this study (and particularly the interviews with young adults) proved to be highly inaccurate. The experiences of Good Shepherd Services and the Center for Family Life make clear that practices that recognize the value of family for youth and that integrate family-focused work in all aspects of foster care services can be successfully developed and implemented, resulting in positive outcomes for youth in care.

**Recommendation #2:**

**Redesign congregate care so that it functions as a service-based, family-like model that ensures the safety and well-being of youth.**

It can be expected that even with full implementation of the first recommendation, there will continue to be a need for congregate care placements for a limited number of youth with specific needs who require residential treatment services. This reality highlights the importance of specifically addressing this study’s findings regarding the marked deficiencies in the current congregate care system. This study makes clear
that the youth who were most likely to report positive experiences in congregate care had found family-like connections and a family-like environment in those settings. The majority of young adults in this study, however, did not describe their group homes or their RTCs as “family like,” but instead, characterized their experiences as highly negative. They made clear that the poor physical conditions of the facilities and, in particular, the locked refrigerators created anything but a “home-like” environment.

As noted earlier, this study identified a host of factors as undermining the quality of youth’s experiences in congregate care – too numerous to be addressed by these recommendations. Three factors, however, were particularly powerful and are focused upon here to ensure that youth who need congregate care placements receive quality care and services: congregate care facilities must be safe environments for youth in care; the staff of congregate care facilities must be appropriately screened, trained, and supervised so that they provide youth with the structure, support, and guidance that they need; and youth in congregate care must be prepared to transition from care to life outside the foster care system.

1) **Congregate care facilities must be safe environments for youth in care.** As stated earlier, professionals and young adults reported a host of dangerous conditions in congregate care facilities. Young adults, in particular, made clear that in many situations, staff had no control in the congregate care environments and violence erupted as a result, and that, in some cases, staff themselves created dangerous situations. The existing regulations on safety appear to have had little impact on the practices of and conditions in many group and residential care facilities.5

If congregate care is to be service-focused and family-like, it must, first and foremost, be safe. To that end, ACS must take the following steps to ensure that all possible protections for youth are in place in group and residential care settings:

- **Work with OCFS to create and implement a toll-free, 24-hour hotline for youth that treats their reports seriously, promptly responds to their reports, and is widely publicized so that youth are aware of the availability of this resource.** The ACS Office for Advocacy maintains this type of service but, in this study, no young adults even mentioned this resource, suggesting that they were not aware of it or did not find it to be a meaningful resource.

- **Develop a standardized critical incident reporting and review system** that solicits the statements of youth as part of the assessment of the incident, ensures an independent review that includes young adults formerly in foster care, and requires documentation of all actions taken.

- **Issue annual public reports on the number of critical incident reports by facility, the nature of these reports, and their disposition.**

- **Require active outreach on the part of staff in the ACS Agency Programming Assistance (APA) unit.** APA staff must make unannounced, periodic visits to congregate care facilities and interview youth outside the presence of congregate staff, and APA must issue annual public reports on the safety conditions at congregate care facilities and the actions that APA has taken in response to identified problems.

5 Title 18 of the New York City Codes, Rules and Regulations, for example, requires that supervisors inform staff that use of alcohol or illegal drugs on the premises of institutions and group homes will result in dismissal (441.4), prohibits demeaning or degrading behavior toward a child (441.8), prohibits discipline in the form of deprivation of family visits, room isolation, and Corporal punishment (441.9), prohibits the use of restraint as punishment (441.12), and prohibits staff’s sexual relationships with residents (441.19). The regulations further require “adequate supervision” (448.3), mandate that facilities be “free from all conditions that constitute a hazard to the life, health or safety” of residents (442.15), and require that staff “take all necessary steps to prevent any resident from intimidating another resident, especially in relation to coerced physical and sexual activities” (442.19).
• **Develop standardized requirements regarding the safety of youth** and their possessions in congregate care facilities (for example, a requirement that all facilities make lockers with keys available to all residents) and that prohibit such actions as locking out youth who miss curfew, “locking in” youth, and denying family visits as a punishment. These requirements must be integrated into ACS contracts with private agencies that provide congregate care.

• **Develop standardized requirements regarding programming in group homes so that youth are productively engaged and their energies directed into safe activities.** These requirements must be integrated into ACS contracts with private agencies that provide congregate care.

In addition, ACS must develop specific safety outcome measures on which it assesses the performance of private agencies and makes determinations as to whether to continue to contract with those agencies for congregate care services. This issue is discussed under the third recommendation below.

2) **The staff of congregate care facilities must be appropriately screened, trained, and supervised so that they provide youth with the structure, support, and guidance that they need.** A consistent theme that emerged from interviews with professionals and young adults was the poor quality of staff at congregate care facilities (although exceptions were repeatedly identified, demonstrating that quality staff who can make profound contributions to young people’s lives can indeed be found and retained). ACS must require private agencies to take the following specific steps to ensure the quality of congregate care staff in their facilities and must facilitate the implementation of these steps with appropriate resources:

• **Institute standardized screening procedures** for all youth care staff, to include criminal records checks, child abuse records checks, and drug testing (with criminal and child abuse records checks and drug testing occurring on a regular basis).

• **Involve youth in interviewing candidates for positions in the congregate care facility and in staff’s ongoing evaluations.**

• **Require participation of staff in a standardized training curriculum,** drawing on the training that ACS has developed and requires of its direct-care congregate care staff, including issues of particular relevance to congregate care (such as adolescent development, how to develop programs for youth in group care facilities, the educational needs of youth, and safety issues), and using experienced staff members as trainers and peer consultants.

• **Promote staff’s ongoing motivation and commitment to work with youth in these settings,** using incentives such as educational benefits (similar to the benefits that ACS offers to its direct-care congregate care staff) and job advancement.

• **Develop and sustain strong supervisory management, support and guidance of staff who work directly with youth.**

The staff training model developed by Good Shepherd Services integrates these features. Close supervision and a rigorous screening process are key components. Staff training includes individual supervisory sessions, group supervisory sessions, interdisciplinary clinical team meetings, on-the-job supervision, and attendance at workshops, seminars, and training institutes. An emphasis is placed on individual and group intervention techniques, methods
for handling various behaviors, and staff functioning as members of a therapeutic team. In addition, staff are asked to self-select into programs that serve adolescents.

3) Youth in congregate care must be prepared to transition from care to life outside the foster care system.

Both young adults and professionals reported very poor preparation of youth for life after foster care (although some young adults – particularly those who received educational and job training opportunities – expressed satisfaction with their “independent living” preparation). Research makes clear that youth are less likely to succeed post-discharge from foster care if they lack education, employment skills, housing, health care and/or connections with adults who will “be there” for them. This study documented that the services offered to youth in each of these areas fall far short of what youth need if they are to take responsibility for themselves when they leave foster care. The study further made clear that in too many instances, the “preparation” begins far too late in the youth’s foster care stay and that after leaving care, youth find that few, if any, aftercare services are available. Accentuating these difficulties were the absence of family-like support and role models while youth were in care and the lack of attention to ensuring youth’s connections with caring adults when they left care.

The transition issues identified in this study are significant and all of them warrant close attention. The next steps, however, must be the first priorities. ACS must implement the following steps:

• **Require, from the time a youth enters foster care, that all private agencies focus on “getting youth ready to leave care.”** All private agencies must develop a plan with each youth regarding his or her goals; the services needed while the youth is in care; the services, supports and information that the youth will need after leaving care (such as a birth certificate, immigration status documentation, and a bank account); and the family and other adult connections that need to be made and/or supported. This plan should be supported by the service plan that is already required for each child and youth in foster care to ensure that youth receive needed services while in care and timely efforts are undertaken to prepare youth for discharge (such as applying for a Section 8 housing voucher).

• **Mandate that each private agency have a sufficient number of full-time educational coordinators for the children/youth in their care.** This individual would work with the Department of Education to ensure that each child’s and youth’s educational needs are assessed and addressed, coordinate their formal and informal educational services, serve as an advocate on their behalf with the educational system, attend meetings with the Department of Education and educational advocates, and advise each young person on educational issues.

• **Require that the discharge of a young person include clear documentation that a specific adult (family member, mentor, or other caring adult) has been identified who has agreed to make a long term commitment to the young person and that the agency has had an in-person meeting with that adult and the young person.** This recommendation is consistent with and further reinforces the ACS policy that took effect in July 2003 requiring concurrent family-based plans for all youth with permanency goals of independent living.
• **Require all private agencies to maintain contact with youth discharged to “independent living” for one year and to provide information to ACS regarding young adults’ outcomes after discharge.** ACS should compile the reported information and issue annual public reports. Among the reported information should be the percentage of youth discharged from each private agency who at any time after discharge: did not have health insurance; was homeless or living in a shelter; was unemployed; had been incarcerated; had been the victim of a crime; relied on public assistance; reported having no one to turn to for help; sought legal services; and sought mental health services.

• **Require private agencies to make aftercare services available to young adults for at least one year following discharge from foster care (including youth who leave care at the age of 21).**

As with the first recommendation, objection might be made to these recommendations as requiring a commitment of unavailable resources. It must be noted in connection with this potential objection that funding is available through the federal Title IV-E program for many of these costs. ACS, in collaboration with OCFS, must ensure that systems are in place to maximize federal reimbursement claims under Title IV-E and to take full advantage of the opportunities under Title IV-E for obtaining federal reimbursement for administrative and training costs.

There are several examples of programs – both in New York City and in other communities – that could serve as models for transitional services for youth preparing to leave or who have recently left foster care. The SILP approach already implemented in New York City received high marks from the respondents in this study as a model for preparing youth to transition from foster care. Further expansion of SILPs and the development of other apartment-based approaches for youth must occur. The following programs offer examples of approaches that could be replicated in providing services and transitional housing for youth:

• The transitional program at Covenant House in New York City (which focuses on several areas – job training, placement, counseling services, and assistance in finding stable housing – and expects that youth will work and contribute toward program costs with the money that they contribute returned to them upon graduation from the program).

• The Enhanced Independent Living Services Program at Good Shepherd Services (which provides a program of specialized activities targeted to meet the developmental needs of youth, addresses specific life skills, and includes work internships, mentoring, and specialized retreats).

• The partnerships developed by the Edwin Gould Academy in Rockland County, NY (which include collaborations with Mount Sinai Hospital to provide mental health services to youth irrespective of health insurance coverage and pre-arranged legal services for youth who are arrested).

• The Bridges to Independence Program at United Friends of Children, Los Angeles, CA (which provides beds in apartment units for 18 to 20 year old graduates of the foster care system who face imminent homelessness and require additional support to achieve self-sufficiency).
• Lighthouse Youth Services in Cincinnati, Ohio (which provides transitional housing for youth that includes opportunities to “learn by doing” through a 13-unit life skills training curriculum).

Recommendation #3:
Ensure full accountability on the part of ACS and the private agencies that provide congregate care for the outcomes that are – and are not – achieved.

The Special Child Welfare Advisory Panel recommended that ACS develop performance-based contracts that specifically mandate quality placements for children and youth in foster care and quality service provision. ACS has attempted to incorporate “performance standards” into its contracts with private agencies, but these efforts have not reached a level at which the contracting process ensures accountability. To achieve this goal, contracts with private agencies that provide congregate care (and future Requests for Proposals) must include outcome measures that are specific to the needs of youth in congregate care. Furthermore, given the extreme variability in congregate care facilities that this study found, it is critical that these standards be applied to all agencies that provide congregate care and that ACS’ decisions regarding continuation of contracts rest on agencies’ performance on these outcome measures. At minimum, the following outcomes should be incorporated – with the exact performance targets set by ACS and possibly modified for agencies that serve youth with intensive needs:

<table>
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<tr>
<th>Outcome Area</th>
<th>Performance Standard</th>
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| Safety                | • The percentage of youth in each congregate care facility who were the subject of a substantiated critical incident report related to staff conduct or the use of restraint or isolation.  
• The percentage of youth in each congregate care facility who were the subject of a substantiated critical incident report related to injury caused by another resident.  
• The percentage of youth on AWOL at any time during the reporting period. |
| Family Connections     | • The percentage of youth with at least weekly in-person contacts with a family member or other caring adult.  
• The percentage of youth with siblings in care who have at least weekly in-person contacts with their sibling(s). |
| Educational Services   | • The percentage of youth enrolled in school.                                           |
| Transition from Care   | • The percentage of youth discharged from the agency’s care who are actually reunited with parents or placed with extended family.  
• The percentage of youth discharged with an adult having been identified as a long-term resource for the youth.  
• The percentage of youth discharged from the agency’s
Transition from Care (cont.)

- The percentage of youth discharged with a specific address that has been verified through a visit to that address.
- The percentage of discharged youth who are employed at time of discharge.
- The percentage of youth discharged from care with money in a bank account.

Contracts also must require careful tracking of outcomes for which performance targets may not, at this point in time, be feasible but which, nonetheless, would allow comparisons among agencies that provide congregate care. These outcomes include:

- The number of thefts of residents’ personal property during the reporting period.
- The number of youth in each facility who were arrested during the reporting period.
- The number of youth moved to another group home or other congregate care facility during the reporting period (including lateral moves among group homes and transfers of youth to lower levels of care).
- For residential treatment centers, the number of youth moved to psychiatric hospitals.

Absent a system that focuses on the achievement of clearly defined outcomes, it will be difficult, if not impossible, to ensure that either ACS or its private contract agencies are fully accountable. In the initial phase of adopting such a system, ACS should, at minimum, demand that providers use “maximum efforts” to achieve specified outcomes, critically assess with private contract agencies their current programming in light of the defined desirable outcomes for youth and their families, and require the collection of data on each defined outcome that can then be used to improve and refine programming (see Center for Assessment and Policy Development, 1999). These data can be used to determine the appropriate performance targets on each defined measure. With that information and in line with the concept of “performance-based contracting,” ACS should tie placement decisions, payment under contracts, and decisions regarding the continuation of contracts with agencies to each agency’s achievement of the established outcomes at the pre-determined performance target levels (see LaFaive, 2000).
This qualitative study focused on the experiences of youth in the New York City foster care system who are placed in congregate care settings. It examined six key factors associated with these youth’s experiences: the quality of their group and residential care placements, the services they need and receive, the safety of the congregate care settings in which they are placed, the extent to which permanency is successfully achieved, the level of youth involvement in planning and decision-making, and the extent to which they are prepared to transition from foster care. The study methodically gathered and analyzed data that reflected the perspectives of professional stakeholders (judges, law guardians, social workers, representatives of private child welfare agencies, and representatives of advocacy and other relevant organizations in New York City) and the perspectives of young adults who had been in foster care and had been placed in congregate care settings. It also sought the views of these stakeholders regarding needed improvements in the foster care system to ensure that youth are well served. Finally, it solicited the institutional perspective of the Administration for Children’s Services (ACS) regarding these issues.

The findings of this study document the marked deficiencies of the current foster care system in serving youth in care. There is a reliance on a group residence model that is focused on behavior control as opposed to service provision and family-like environments; services, particularly in the areas of education and mental health, are of poor and uneven quality; there are serious safety hazards for youth, ranging from significant risks of physical harm to commonplace stealing of youth’s belongings to inappropriate use of restraints by congregate care staff; there is inadequate attention to the permanency needs for youth, particularly in terms of reunification and family connections; youth are, at best, minimally involved in planning and decision-making on matters that directly affect them; and youth are not well prepared to transition from foster care.

Significant changes are needed in three areas to ensure that youth in care are well served: (1) reliance on congregate care as a placement option for youth must be reduced while, simultaneously, foster families for youth are recruited, supported, and appropriately compensated; (2) to the extent that congregate care continues to be used for a limited number of youth, it must be redesigned as a service-based, family-like model that ensures the safety of youth, that provides quality programming by qualified staff, and that prepares youth for transition from care; and (3) ACS and the private agencies that provide congregate care must be held fully accountable for the outcomes that are – and are not – achieved in the areas of safety, well-being and permanency for youth.

These steps must be taken to address the serious issues identified by this study (and assessments undertaken of services to youth in care before this study was conducted). Significant improvements are needed and have been documented in this report. One young adult who was interviewed for this study summed up the goal that needs to be achieved:

“Don’t let the child feel they’re a foster child. Make them feel like they’re one of your own . . . Be open and outspoken. Let them know that they’re like everyone else. You’re [in] a family, you’re like one of mine. Make them feel like they are wanted.”


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Texas Foster Care Transitions Project. (2001). *All grown up, nowhere to go: Texas teens in foster care transition*. Austin, TX: Center for Public Policy Priorities.


CHILDREN'S RIGHTS

Children's Rights is a national advocacy organization that works on behalf of children served by child welfare systems across the United States. Children's Rights' mission is to promote and protect the rights of children who are abused and neglected to grow up in permanent, loving families. By creating beneficial and lasting change in child welfare systems, Children's Rights ensures that children who are dependent on these systems stay safe, receive quality care and services, and return to their own families safely or find adoptive families so that they can have healthy childhoods that lead to productive adult lives. Children's Rights uses a unique strategy that combines advocacy, policy analysis, public education, and targeted litigation to improve the quality of child welfare services. Originally a project of the American Civil Liberties Union, Children's Rights became an independent non-profit organization in 1995 under the leadership of its Executive Director, Marcia Robinson Lowry.

JUVENILE RIGHTS DIVISION, THE LEGAL AID SOCIETY

The Legal Aid Society is the nation's largest and oldest provider of legal services to poor people. The Juvenile Rights Division provides comprehensive representation as law guardians to children who appear before the New York City Family Court in child protective, juvenile delinquency and other proceedings affecting children's rights and welfare. In 2002, attorneys and social workers represented more than 33,000 children, including approximately 29,000 in child protective matters. The organization's representation of adolescents in foster care includes assistance with all matters related to their placements as well as their transition out of care.

LAWYERS FOR CHILDREN

Lawyers For Children, Inc. was founded in 1984, and remains one of the leading professional, not-for-profit organizations in New York City dedicated to representing children whose parents or guardians have placed them into foster care. In addition, the organization provides legal and social work services to children who are the subject of abuse, neglect, termination of parental rights, adoption, guardianship, paternity, custody, and visitation proceedings. The goal is to help find a safe, permanent and loving home for each child that the organization represents by providing them with the highest quality legal and social work services, as well as to advocate for the rights of children in foster care on a system-wide basis.
ACRONYMS AND GLOSSARY

ACRONYMS

ACS: Administration for Children’s Services [the public child welfare agency in New York City]
IRB: Institutional Review Board
JRD: Juvenile Rights Division of The Legal Aid Society
LFC: Lawyers for Children
NSCAW: National Survey on Child and Adolescent Well Being
OCFS: Office for Children and Family Services [the New York State child welfare agency]
PINS: Person in Need of Supervision
RTC: Residential Treatment Center
GLOSSARY

Congregate care: Any form of group care for children and youth; in the child welfare system, group care settings for children and youth who have been removed from the custody and care of their parents or guardians.

Foster boarding home: A family-based setting in which children and youth in the custody of a public child welfare agency are placed under the care of licensed foster parents.

Group home: A family-style home for 7 to 12 children who are at least 5 years old.

Law guardian: A lawyer who represents a child or youth in foster care.

Maternity home: As used in this study, a residential facility for the care and maintenance of children under the care and custody of New York State and the City of New York who are pregnant.

Mother-child facility: A facility for the care and maintenance of not more than 10 mothers, who themselves are not children, and 10 babies of these mothers.

Research Partners: Children's Rights, Juvenile Rights Division of The Legal Aid Society (JRD), and Lawyers for Children (LFC)

Residential Treatment Center (RTC): An institution operated by or through a contract with a public child welfare agency (the Administration for Children's Services in New York City) for children whose needs for services or supervision demand 24-hour residential care.

Residential Treatment Facility (RTF): An inpatient psychiatric treatment residence operated by the New York State Office of Mental Health or the New York State Office of Mental Retardation in which care is provided under the direction of a physician to children who are under the age of two.

Therapeutic foster care: A family-based setting in which children and youth in foster care who have needs for highly specialized care and services are provided with care by specially trained, highly qualified, and intensively supervised foster parents.
APPENDIX A

Adult Stakeholder Interviews

Private Child Welfare Agencies Represented in the Study
Catholic Home Bureau
Children's Village
Edwin Gould Academy
Good Shepherd
Graham Windham Services
Hawthorne Cedar Knolls
Jewish Child Care Association
Lakeside Family and Children Services
Leake & Watts
Miracle Makers
Saint Agatha Home
Saint John's Residence & School for Boys
Wayside Home for Girls
(In addition, representatives of Hegman, the ACS direct-care facility, were interviewed)

Advocacy and Other Organizations Represented in the Study
Advocates for Children's Rights
Agenda for Children's Tomorrow
Bob Lewis
Boys and Girls Harbor
C-Plan
Center for Family Representation
Child Welfare Organizing Project
Citizens' Committee for Children of New York
Covenant House
Foster Care Youth United
Harlem Children's Zone
The Door
Urban Justice Center
Youth Advocacy Center

Boroughs Represented by the Judges Who Were Interviewed
Bronx
Brooklyn
Manhattan
Queens
Staten Island
APPENDIX B
Members of the Project’s National Advisory Board

Rosemary Avery
Professor, College of Human Ecology
Cornell University
Ithaca, New York

Jean Hoffman
Director, Adoption Services Division
Michigan Family Independence Agency
President, National Association of State Adoption Programs
Lansing, Michigan

Gary Mallon
Associate Professor and Executive Director
National Resource Center for Foster Care and Permanency Planning
at the Hunter College School of Social Work
New York, New York

Anthony Maluccio
Professor, Boston College Graduate School of Social Work
Boston, Massachusetts

Joan Morse
Director, Independent Living Resource Center
Hunter College School of Social Work
New York, New York

Jennifer Nelson
Director of Youth Development
Southwest Key Program
Austin, Texas

Robin Nixon
Director, National Foster Care Coalition
Connect for Kids
Washington, D.C.

Gary Stangler
Director, Jim Casey Youth Opportunities Initiative
St. Louis, Missouri
APPENDIX C
Representatives of the Administration for Children’s Services Who Were Interviewed

Martin Baron: Deputy General Counsel, Department of Legal Service
Gabriel Brodhar: Director of Housing, Planning and Development
Rosemary Brown: Director of Services
Frank Callagy: Supervising Consultant, Agency Programming Assistance
Frances Carrero: Director of Social Services, Department of Congregate Care
Harry Comeau: Executive Assistant to Assistant Commissioner, Division of Child Protection
Diane Connolly: Assistant Commissioner, Office of Quality Improvement
Jessica Davis: Director of Program and Planning, Office of Youth Development
Ronnie Fuchs: Director of Policy and Training, Office of Youth Development
Hanaa Girgiss: Acting Assistant Director, Foster Care and Preventive Services
Jeanny Heller: Deputy Director, Agency Programming Assistance
Jennifer Jones Austin: Deputy Commissioner, Policy and Planning
Linda Lausell-Bryant: Associate Commissioner, Office of Youth Development
Alexandra Lowe: Special Assistant to Deputy Commissioner, Foster Care and Preventive Services.
Eric Nicklas: Acting Assistant Commissioner, Research and Evaluation
Lisa Parrish: Deputy Commissioner, Foster Care and Preventive Services
Rachael Pratt: Director, Parent Recruitment and Expedited Permanency
Marc Stolzenberg: Attorney: Department of Legal Services
Hee Sun Yu: Associate Commissioner, Medical Services Planning and Development
Gregory Weir: Acting Associate Commissioner, Department of Congregate Care Services
Anne Williams-Isom: Special Counsel to the Commissioner: Associate Commissioner
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