

Foster Care Services in Transition: Some Lessons from International Experience

Child foster care systems in many countries have been and still are undergoing substantial changes. However, the idea of professionally-led, independent social care practices akin to GP practices in the UK seems to be quite a unique and innovative approach to challenges facing the foster care system in the UK.

Although these changes exhibit similar trends, i.e. increasing diversity of the service delivery systems, they have different drivers, i.e. they are either a direct result of public policy change in child care triggered by bad performances of the systems and tragic events, or they emerge as a result of adjustment strategies in which service providers are responding to changes caused by broader policy reforms or a more long-term policy development. For instance, in South-Australia and many states in the US such as Michigan, Kansas, Illinois, Florida and Texas changes in the systems followed a comprehensive overhaul of what was seen as poorly performing the services, and in Ontario in Canada a series of government reforms were triggered by a series of inquests into deaths of children who had received child welfare services in the 1990s. In Denmark, the foster care system is adjusting to major structural change and in Sweden foster care services have been undergoing more gradual profession-driven changes.

Changes in child foster care systems have in common that there is a clear separation between commissioning and provision of services, they have privatisation as an ingredient, and they affect or are more directed towards the supply-side of the foster care system. More precisely, they apply to the definition of tasks and responsibilities and where to draw the line between commissioning and provision, the public and the private sectors, and they apply to the various means by which this division is established and managed. However, they vary greatly in degree and motives.

The demand-side of the child foster care systems stays similar across countries like UK, Sweden, Denmark, Australia and the US, i.e. financing, child protection services and assessment of needs remain the responsibility of public authorities and public services. In Canada however, financing is public but child protection services and assessment of needs are in the hands of private-non-profit organisations operating at arm's length from the Ministry. These private non-profit organisations hold both a commissioning and a provider role, but in the other countries usually social services departments keep the commissioning role. In general, needs for foster care placements are growing, the length of time in a foster placement is increasing, there is more emphasis on placements with foster carers as opposed to residential care, and there are increasing concerns about outcomes and life chances for the looked after children and young people. A call for more stability and continuity in the lives of children looked after by public authorities is a common feature across those countries. Australia, New Zealand and Canada have in common that there is an overrepresentation of indigenous children in foster care which has a supply-side effect since kinship care is prevalent and a distinctive and institutionalised feature of the foster care systems¹.

On the supply-side of the foster care systems in those countries we find public as well as private provision of services in which independent private-non-profit fostering services have developed from a more voluntary based system. In addition the systems are now becoming increasingly more professionalised in the sense that more members of their staff who deal with looked after children and their fostering families have professional qualifications, mostly qualified social workers. Alongside public service organisations, these organisations provide foster care placements and various related services such as counselling, health and educational support services, training and support for foster carers, and regular visits and monitoring of the looked after children and young people.

SCANDINAVIA

In Denmark and Sweden the public provision of foster care services is the dominant mode with private provision only on a small scale. Local authorities are the biggest providers and they have been commissioning services from independent, private-non-profit, highly professionalised providers. Public and private provision has been seen as running hand in hand, since the private organisations have been an important source of support, reserve capacity and innovation, akin to the UK experience².

In Sweden the process of change has been gradual and a part of a process of spontaneous privatisation where professionals have gone private and provide various types of services to local authorities. It is a profession-driven privatisation pursued as a strategy of professionalisation³ and as a response to increasing demand for high quality, knowledge-based services for children in foster care⁴. In the field of foster care and services for looked after children a number of independent organisations work in partnership with local authorities all over Sweden offering local authorities information, professional expertise as well as practical advice and a range of services for foster carers and their children, and some operate as interest groups raising awareness and improving the standard of services for looked after children⁵.

In Denmark the balance between the degree of public or private provision seem to be going in an opposite direction, i.e. moving from private back to public provision of foster care services. The public sector in Denmark is undergoing centrally-driven, major organisational restructuring involving big scale mergers of local authorities planned to improve their capacity to plan, finance and deliver a comprehensive set of services. Fewer but bigger local authorities are increasingly providing the full scale foster care services themselves and reducing the amount of services commissioned from private providers. In an attempt to maintain their share in the provision of foster care services, private providers are struggling to adjust in competition with local authorities by developing their services and moving into new areas within the child care service sector⁶.

LAs provide most of these services themselves but have commissioned services from these organisations often on an unplanned basis similar to “spot purchased” services purchased by LA from IFAs in Britain⁷. In 2005, one LA (Hilleröd kommune) formed a public-private partnership with one of these organisations operating in the Copenhagen region (Fredriksborg Amt Family Care) in which the partners have established a more formal and long-term contract to co-operate⁸. The main objectives are to simplify administrative processes, improve coherence and continuity in the overall process of foster care placements and the carrying out of the care plan, and to explore ways of cost-containment without reducing quality of services⁹.

Overall, Sweden and Denmark have much in common with the UK system of services for looked after children and young people^{10 11}. Although providing only a small proportion of total services provided for looked after children, a growing number of independent fostering providers has become increasingly more professionalised and staffed by qualified social workers, social pedagogues, teachers specialised in services for children with special educational needs and/or social workers trained as family therapists. Most social workers have a background in child care services inside the public sector, a considerable experience and expertise in this field of service provision, and are frequently cooperating with their professional colleagues in the public sector who have a similar mind-set and share the understanding of the process of planning services for children.

Also, the working arrangements do have more in common with what has been termed in the UK as “spot-purchasing” of services¹². However, the lessons from these countries offer little by means of independent evaluation in terms of measuring outcomes of services, whether in measuring contract performance or outcomes for the children. Countries with a more big scale publicly financed - privately provided foster care services may be more helpful in providing information based on experience from applying outcome-measures, performance indicators and various payment schemes.

THE ANGLO-SPHERE

In South-Australia and in Michigan, Kansas, Texas, Florida, Ohio and Illinois and some other states of the US the changes form a part of liberalisation strategies introducing principles of market into public services and as such they are politically planned or policy-driven. With an already large private sector in this field of service provision, the aim in most cases is now to complete the separation between commissioning and provision and to eliminate a dual foster care system by outsourcing all foster carer services, i.e. foster placement and related services, to the private sector through the use of performance-based contracting. By operating agencies providing both services and contracts for the same service the public sector was, in fact, regulating itself. The route towards better quality of foster care services is seen to be that of building a stronger accountability by eliminating a potential conflict of interest. That involves a complete separation of the roles of commissioning and provision of services, in which public authorities are left with the role of commissioning and regulation where greater emphasis is placed on contracting skills and strengthening of contract monitoring and licensing^{13 14 15}.

Dangers of Monopoly: South-Australia

Independent evaluation of the South-Australian case has not been positive. Under the requirements of the Australia's National Competition Policy, foster care services in South-Australia, responsible for recruitment, assessment, training and ongoing support of foster carers were put out to public tender in 1997. After reviewing all of the tenders a decision was made to award the two metropolitan area services to two different independent providers. Under intense lobbying of the minister for family and community services by one of the agencies, that decision was overturned and both metropolitan areas were awarded to that agency¹⁶. In consequence, the competitive tendering in South-Australia resulted in a monopoly provision of services in the metropolitan areas in which some old foster care services lost their funding and were squeezed out of service, and thus a capacity to deliver and compete for foster care services in the future went lost.

Managed care and outcome-based contracting: The US experiences

The US cross states experiences can offer some lessons from experimenting with various models of performance indicators, outcome measures and payment systems under scrutiny from the U.S General Accounting Office¹⁷ and professional scrutiny of standards for child welfare services by the Child Welfare League of America¹⁸.

A study of the U.S. General Accounting Office (GAO) (2000) highlighted innovative financial approaches used in foster care in 27 localities across 14 states. It found that a number of states and localities were using managed care initiatives, and that they set performance standards, and incorporated financial incentives in their contracts to hold foster care providers accountable for performance and results. For instance, contractors that incur expenses a specified rate are liable for up to 3 percent of the excess costs; they may retain up to 3 percent of savings if costs are lower.

In most of the 27 initiatives studied by GAO, states and localities had contracted with experienced private non-profit, community based providers – many of whom had had a long history of providing child welfare services for states and localities. As managed care entities operating under a capitated payment scheme, these providers take lead responsibility for co-ordinating specified child welfare services for a defined population of children and families. As a single point of entry to the service system, the managed care entity usually must provide, create, or purchase a wide range of services to meet the needs of children and families. If not providing services itself, this primary contractor may develop and subcontract with a network of service providers to make available the services referred clients need.

However, there were some variations in the way states and localities organised their managed care model^{19,20}. The managed care arrangements generally fell into one of the four following managed care models:

1. Public Model:

A public model maintains the traditional management and service-delivery structure while the public agency incorporates managed care elements into its own practices and existing contracts with service providers. Illinois is an example here. Illinois began performance contracting in 1997, received an award from the Harvard Innovations in American Government programme in 2000, and has been pointed out as a very good example for other states to follow in designing outcome-based contracts²¹ (see more below).

2. Lead Agency Model:

A public agency contracts with a private entity that is responsible for coordinating and providing all necessary services – either directly itself or by subcontracting with a network of service providers – for a defined population of children and families. Michigan and Kansas have adapted this model. Five contractors and 25 non-profit providers offer foster care services and programmes in Kansas (by Nov. 2003). The University of Kansas works with the Department of Social and Rehabilitation services to provide training and evaluation services from the private foster care agencies. Researchers at the Heartland Institute describe the privatization of foster care in Kansas as a great success (October 2003)²² (see more below).

3. Administrative Services Organisation Model:

A public agency contracts with a private organisation for administrative services only, and direct services are structured as in the lead agency or public agency models. Massachusetts has combined this model with a lead agency model. Massachusetts took an incremental approach and did not introduce performance standards in the lead agencies' contract until the third year of operation, and sufficient information had been collected to establish a baseline from which to set standards. Massachusetts has reported increased overall costs of its initiative mainly due to increased administrative costs, but reported better outcomes since more children had moved from residential treatment to less restrictive settings.

4. Managed care Organisation (MCO):

A public agency contracts with a private organisation as in lead agency model, but the MCO arranges the delivery of all necessary services by subcontracting with other service providers and does not itself provide direct services. Indiana adapted this model but no reports on outcomes were provided in the GAO's study in 2000.

In every initiative the state or locality had continued to conduct all child protection functions related to investigating reports of child maltreatment and recommending to the courts whether a child needs to enter the child welfare system for protective or any other services. A child enters the managed care system on the basis of a referral from the state or locality to the managed care entity. In some initiatives the states and localities also maintained its presence by retaining the authority to approve contractors' decisions related to reducing a child's level of care.

To more effectively monitor the progress of children and families and hold service providers accountable for their services, states and localities were taking steps towards a more performance-based and results-orientated approach. While moving from a process-monitoring environment to a performance-based approach, data systems have become the linchpin between a state or locality's efforts to identify and measure outcomes and thus fully implement such a performance-based, result orientated system.

The GAO study from 2000 identified common outcome measures used to determine the success of performance-based contracting initiatives. Outcomes and measures are grouped into five categories including 1) safety, 2) permanency, 3) well-being, 4) stability and 5) satisfaction.

The initial evaluation of these initiatives found that about half of them moved greater numbers of children into permanent homes, and often more quickly, than conventional programmes. The study also cited improvements in school performance, family relationships and parenting skills.

Kansas (2003) was the first state in the US to completely outsource its adoption, foster care and family preservation programmes and, with considerable public controversy, shift them to managed care or “capitated” payment methods in 1997. In 2000 the “managed care” model, which had paid a flat rate per child, was changed to a system that reimbursed contractors monthly based on the number of children they serve. Kansas Action for Children, an advocacy group for children’s welfare issues commented that the managed care model had several problems, the foremost being a lack of attention to prevention programmes and services that keep children out of foster care in the first place. The Child Welfare League of America released a report in 2003 analysing the Kansas experience. The report found that Kansas had moved too fast to full outsourcing in just one year and identified four major issues that should be taken into account by other states contemplating a similar system. These were: 1) rapid systemic changes are not advisable, 2) reliable cost data are crucial, 3) outsourcing will not necessarily control costs, and 4) outcomes and performance measures are critical and must be refined based on experience²³.

The Illinois (2004) Department of Children and Family Services used a contract which specified that, when private child placing agencies reunite foster children with their families, the reunification must last for at least 12 continuous months if the agency is to claim a positive performance outcome. Thus the agency must work diligently to ensure the reunification process is successful. Illinois uses a system of bonus payments to enforce quality contracting provision. It offers bonuses to contractors that move more than a specified percentage of their caseload into permanent living arrangements. Illinois has been particularly recommended as a good model for an outcome-based approach for all foster care services²⁴.

Short-lived regulation: Ontario, Canada.

The Canada story gives a different lesson. In Ontario, the biggest province in Canada with population size of 12,6 millions, the government's role in child protection is to legislate, fund and monitor the child welfare system. The Ministry of Children and Youth Services in Ontario (the Ministry) is responsible for services to children and youth. The Ministry sets policy and provides program design for child welfare. Under the provisions of the Child and Family Services Act (the Act), the Ministry contracts with 53 local non-for-profit children's aid societies (CAS) for delivery of the legislated Child Welfare Services Programme in their respective jurisdictions²⁵.

As part of the Child Welfare Services Programme, child protection services are provided by a single local CAS in each 53 areas all over Ontario. Each CAS operates at arm’s length from the Ministry and is governed by an independent volunteer Board of Directors. CASs have exclusive responsibility for the provision of the services under the Act. The Ministry's nine regional offices monitor the CASs in their regions.

In the Ontario Auditor-General published his first value-for-money audit report of the Child Welfare Services Programme²⁶. The review of the Auditor General found that under the Programme, transfer payments from the Ministry to CASs in Ontario had began to increase substantially in the late 1990s and by 2004/05 these had more than doubled. The overall Ministry transfer payments had increased at a significantly higher rate than the key underlying service volumes. While CAS expenditures net of CAS-generated funds more than doubled between the 1998/99 and 2004/05 fiscal years, the key service volumes, including the number of families served increased by only about 40%²⁷. Moreover, although the Ministry had three accountability mechanisms to help ensure that it received value for money spent by the CAS, there was no evidence in most cases that Ministry staff even reviewed these reports or followed them up with CASs staff to ensure that necessary corrective actions were taken.

There were some systemic reasons for this dramatic rise in Child Welfare Services expenditure which date back to events in the 1990s. After a series of inquests into the deaths of children who had received child welfare services in 1998, the Ministry of Community and Social Services, then responsible for Children's Services, had responded by launching the Child Welfare Reform in 1998-2000. This included amongst other things a new funding framework (1998), an introduction of a mandatory, standardised risk assessment tool (1998), the Ontario Risk Assessment Model (ORAM), and legislative changes (2000) adding emotional harm and neglect to the list of conditions for which children require protection.

It has been consistently noted by observers that imposition of a standardised risk-assessment system has the effect of erring on the side of caution, and thereby increasing the number of children deemed to be in need of protection. The ORAM is often referred to as a "deficit model" of assessment because it highlights areas in which families are deficient and identifies those things families are unable to do. A more balanced means of assessment, often characterised as a "strength-based model" still considers the risk factors for a child or family, but also highlights what a family is able to achieve and what strengths children's services can draw upon from the extended family or the community. These strengths can often be used to provide care and support while requiring less formal and costly intervention from child welfare authorities²⁸. Since the implementation of ORAM in Ontario the number of families referred to the child welfare system has nearly doubled and the types of cases being referred have changed dramatically²⁹.

In 2004 the a Ministry of Children and Youth Services (it had just been established and taken over children's welfare services from the Ministry of Community and Social Services) created the Child Welfare Secretariat to address the key conclusions of a newly published Child Welfare Programme Evaluation. It followed that the Child Welfare Transformation Agenda, a strategic plan for a flexible, sustainable and outcome oriented service delivery model, was launched in 2005³⁰.

Children's Aid Societies are private-non-profit organisations operating at arm's length from the Ministry. When a child has, on court order, become a Crown ward, Children's Aid Societies assume the parental responsibility for the child, and they plan and provide a full range of children's protection services in their respective area, i.e. the intake processes, needs assessments, care planning and decision-making processes about service specification and delivery. In other words, they hold both a commissioning and a provider role. In this respect, they take up similar functions as Local Authorities in Britain. But while they are private organisations, they also have a monopoly provision of child protection services in their respective areas. In that position they obtain a monopoly of information and knowledge about how professional judgements and administrative practices intersect and the resulting effect that intersection has on quality and costs.

CONCLUSIONS

There is not much to be found in the international literature resembling the idea of social care practices akin to GP practices in the UK. This idea seems to be quite innovative and thus deserve to be explored by ways of piloting in which a carefully design model, sensitive to the particularities of the UK context can be tested out.

In designing a pilot and developing the new UK model of services for looked after children, there are some lessons to be learned about the systemic effects of a policy-driven intervention and the dangers of monopoly (Australia), about developing strategic instruments such as contracts based on performance indicators and outcome measures linked to payment systems and financial incentives (various US experiences), about the role of the purchaser/provider split in creating more independent and autonomous decision-making, and thereby driving professionalisation (Scandinavia), and about a range of models illustrating where to draw the lines of division of tasks and responsibilities, between

commissioning and provision and between public and private provision, which are ranging from a very narrow model (Scandinavia) to a complete model (Ontario Canada).

The lesson from Canada lies in the issue of regulation. Like in the case of Victoria Climbié in Britain, deaths of children who had received welfare services in Ontario had initiated a stream of policy programmes and accountability mechanisms.

The Canada story is well captured in John Kenneth Galbraith's dictum: "The life-cycle of the regulator is very short". At the beginning, in a flush of determination, a policy reform is implemented and numerous reporting practices and reviewing mechanisms to ensure accountability are put in place. There is then a period of routineization of procedures. But soon reports are written, but not read - and no actions follow. The regulators may become sociable with the regulated - or "captured", - and regulation becomes ineffective. It may take a crisis or alarming statistical indicators to trigger a new cycle.

Internationally, child welfare services are in a state of transition. Elements of devolution, diversity, flexibility, incentives, outcome-focused measurements, performance indicators, and spreading of best practice based on research evidence are common ingredients in those changes. Policies and programmes including various mixtures of these elements are marking a cultural shift in this field of public services.

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