United States General Accounting Office

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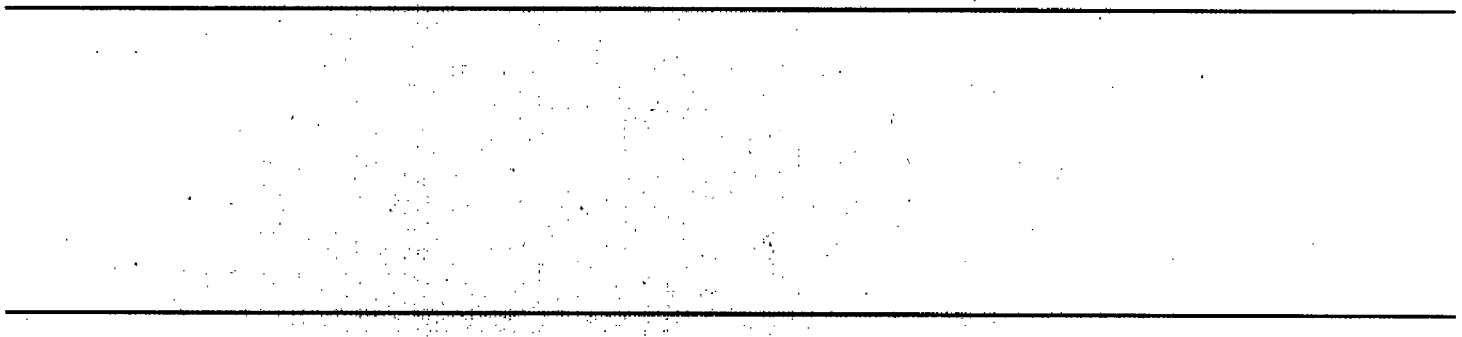
Report to the Chairman, Subcommittee on Human Resources, Committee on Ways and Means
House of Representatives

April 1994

FOSTER CARE

Parental Drug Abuse Has Alarming Impact on Young Children

GAO/HEHS-94-89



GAO

United States
General Accounting Office
Washington, D.C. 20548

Health, Education, and
Human Services Division

B-251314

April 4, 1994

The Honorable Harold E. Ford
Chairman, Subcommittee on Human Resources
Committee on Ways and Means
House of Representatives

Dear Mr. Chairman:

As the nation's policymakers consider national health care and welfare reforms, the information contained in this report should be valuable in helping frame policies that can significantly impact one of our most vulnerable population groups—young foster children—and their families. The average number of children in foster care nationwide increased 53 percent in 5 years, from 280,000 in 1986 to 429,000 in 1991. The three states we reviewed care for over 50 percent of the foster care population. In those states, the number of children in foster care increased about 66 percent during that period and the number of young foster children—those 36 months of age and younger—more than doubled. Additionally, more young foster children had health-related problems, including prenatal exposure to drugs, in 1991 than in 1986.

This report responds to the first of three issues in your request; that we compare and contrast the population sizes and distinctive characteristics of young foster children in 1986 and 1991. As agreed, we plan to report later on the two remaining issues: (1) how and to what extent the service needs of young foster children are identified and met, and (2) the areas where federal assistance to states could best serve the needs of young foster children and increase their chances of becoming self-sufficient or, at a minimum, less dependent on government assistance later in life.

We reviewed foster care programs in California, New York, and Pennsylvania, the states with the largest average foster care populations in 1991. We analyzed statewide foster care databases for California and New York and reviewed random samples of case files for 1986[1] and 1991 from those of 32,123 young foster children in three locations: Los Angeles County, New York City, and Philadelphia County.[2] These locations cared

[1]For one location in the 1986 sample, program officials could not locate about 40 percent of the requested case files. Appendix I describes the steps we took to ensure that comparisons between 1986 and 1991 case file review results were appropriate.

[2]Pennsylvania does not have a statewide foster care database; to review this state's foster care program we relied on summaries that the state compiles from aggregate data submitted by its counties.

for a substantial portion of each state's young foster children in 1991: 44 percent in California, 81 percent in New York, and 29 percent in Pennsylvania.

Results in Brief

The 1991 population of young foster children is significantly different from the 1986 population in the locations reviewed in a variety of ways: the 1991 population size is much larger, more of these children entered foster care due to some form of neglect, their biological parents are more likely to abuse drugs, these children have more health-related problems and are at high risk for further problems due to prenatal drug exposure,[3] and they are more likely to be eligible for federal maintenance payments.

The number of young foster children increased at almost twice the rate of the general foster care population. Neglect and caretaker absence prompted an estimated 68 percent of removals, up from 47 percent in 1986. We estimate that families where at least one parent was a drug abuser increased from 52 percent to 78 percent. An increasing percentage of children had serious health-related problems in 1991 and most of them were prenatally exposed to drugs. Specifically, an estimated 58 percent of young foster children had serious health-related problems in 1991 compared with 43 percent in 1986. Those at high risk for problems due to prenatal drug exposure increased from 29 percent to 62 percent over this period. Cocaine was the most prevalent drug children were prenatally exposed to in both years; documented prenatal cocaine exposure increased from 17 percent to 55 percent between 1986 and 1991. A larger percentage of young foster children qualified for federal maintenance payments in 1991 than previously. At the same time, the growing number of young foster children increased overall maintenance expenditures, compounding their financial impact on government. Federal and state governments in these three states alone spent over $2 billion in 1992 to maintain foster children of all ages.

These changes have implications for federal foster care and health care programs. Both federal and state expenditures have felt the impact of the growth in the number of young foster children and the decline in their overall level of health. Further, two broad service needs overlap foster and health care programs. First, drug abuse treatment programs for biological mothers and pregnant women are needed to reduce the risks associated with prenatal drug exposure and the likelihood that children will be

[3]We included alcohol abuse in our definition of drug abuse. However, the documented incidence of alcohol use was low, about 6 percent in 1991 and 3 percent in 1986.

removed from their families. Second, services to address the health and developmental needs of drug-exposed children are needed to treat their problems. While few alternatives to foster care currently exist for many of these families, meeting both of these service needs should increase the possibility that such families can be reunified and leave the foster care system. However, drug abuse, to the extent it continues to occur, will remain a hidden contributor to the costs of various federal programs.

Background

While the federal, state, and county governments and foster parents share responsibility for providing care and services to foster children, the Department of Health and Human Services (HHS) is responsible for the management and oversight of federal programs benefiting foster children. The programs are authorized primarily by the Social Security Act. The act, in part, authorizes expenditures to (1) maintain foster children who are eligible under the Aid to Families with Dependent Children (AFDC) program, (2) assist states in providing child welfare services, and (3) provide medical care. Primarily, HHS establishes federal regulations and monitors states' compliance with them for children placed in federally funded foster care and other programs under the act and administers federal funding for them.

Federal expenditures for the administration and maintenance of AFDC-eligible foster children are authorized under title IV-E of the Social Security Act. Those expenditures increased from about $637 million in 1986 to over $2.2 billion nationwide in 1992. The federal portion of foster care maintenance costs varies by state and is linked to a state's Medicaid matching rate. The federal portion ranges from 50 percent to 83 percent of the maintenance cost for AFDC-eligible foster children; states or counties are responsible for the full cost of maintaining foster children who are not eligible for AFDC benefits. Thus, payments to foster parents for the care of an AFDC-eligible foster child are comprised of federal, state, and in some cases county monies.

In addition to maintenance funds under title IV-E, federal funds authorized in other titles of the Social Security Act may be used to provide medical and other needed services to foster children. States may participate in programs such as title IV-B, federal matching grants for various child welfare services; title XIX, Medicaid, for medical services for foster children; and, title XX, block grants for a wide array of social services for children. Data were unavailable to estimate the additional federal, state, and county expenditures for these other services for foster children.

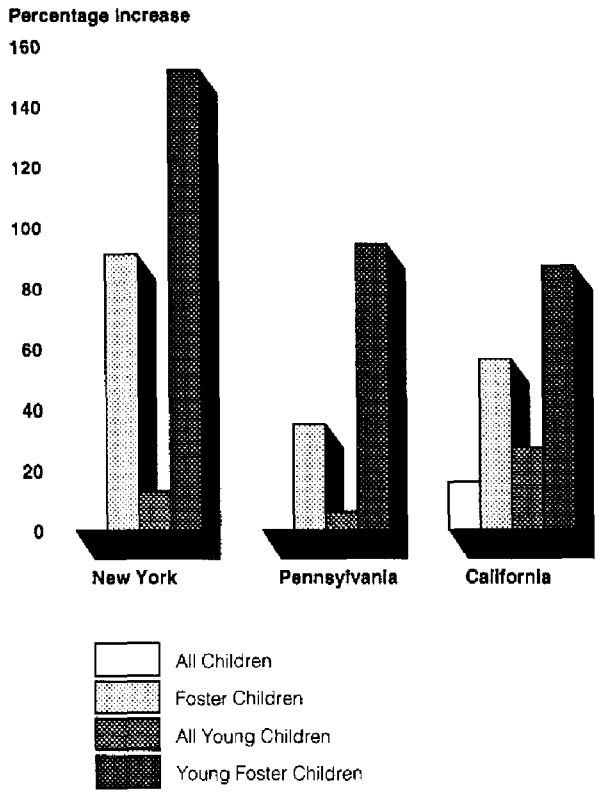
However, we previously reported that median costs associated with newborn medical care for infants known to be prenatally drug-exposed were approximately $1,100 to $4,100 higher (in 1989 dollars) than for other infants. Further, an HHS study provides an example of Medicaid costs in California from 1986 to 1988 for children from birth to 24 months of age. HHS reported a 2-year average Medicaid expenditure of $1,551 for children who were not identified as being prenatally exposed to drugs compared to $2,285 for those who were known to be exposed.[4] Further, medical expenses for drug-exposed foster children from birth to 12 months of age were 62 percent greater than the medical expenses for drug-exposed children who were not in foster care.

More Young Children in Foster Care

The foster care populations in the states reviewed increased dramatically between 1986 and 1991, with the number of young foster children increasing at a faster rate. The total foster care population in these states increased 66 percent while the number of young foster children increased 110 percent. During the same years, the total number of young children in these states increased 19 percent, indicating that a greater percentage of all young children in these states entered foster care in 1991 than entered previously. (See fig. 1 and tables II.1-II.4 in app. II.)

[4]An Exploratory Analysis of the Medicaid Expenditures of Substance Exposed Children Under 2 Years of Age in California, Office of the Assistant Secretary for Planning and Evaluation and Health Care Financing Administration, HHS (1993) (study prepared by SysteMetrics, a division of MEDSTAT Systems, Inc., Cambridge, Mass.). The average was calculated for all children receiving Medicaid benefits in California, not just foster children. It also excluded costs for the federally mandated Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services and delivery services at birth. However, we believe that this is a reasonable minimum estimate of average costs for foster children as well.

Figure 1: Increase in Foster Care and Child Populations in Three States Between 1986 and 1991



Note: Part of New York's increase in foster children is due to the provisions of the New York Supreme Court case, Eugene F., which required all foster children placed with relatives to be included in foster care caseloads and eligible for services.

Pennsylvania's count of "Young Foster Children" consists of all foster children under age 5, as its aggregate data did not break out children under age 3.

California and New York foster children counts represent all children in foster care at any time during the review year; Pennsylvania data for foster children represent year-end counts, as comparable data were not available.

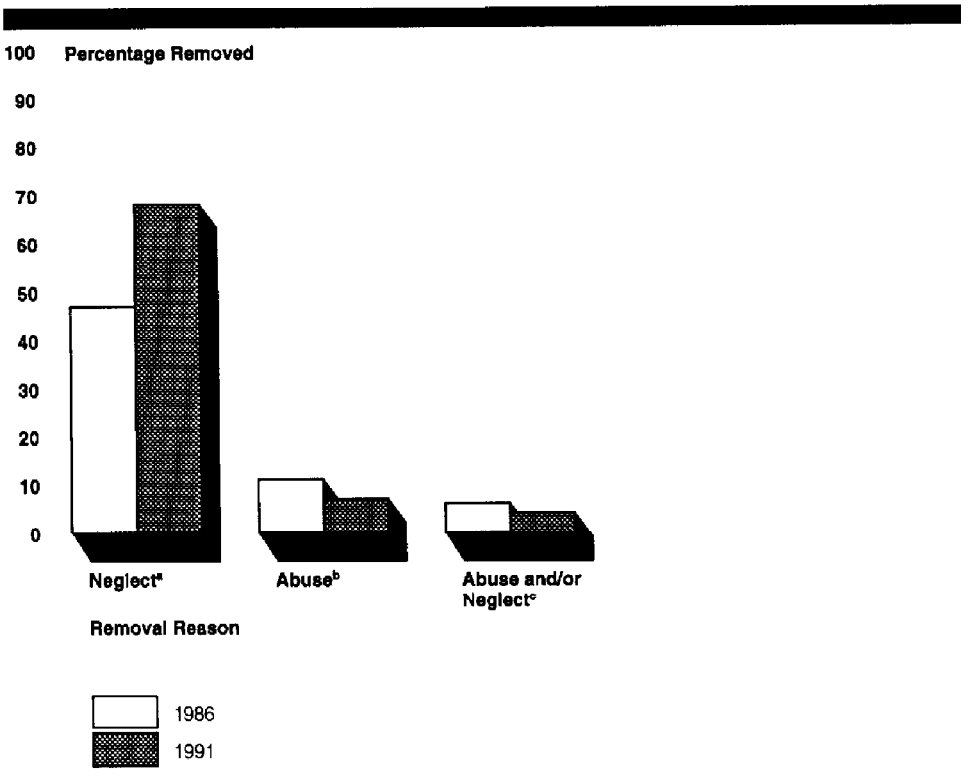
Sources: California and New York—state databases; Pennsylvania—aggregated state data; except "All Children and All Young Children"—Bureau of the Census midyear estimates.

Neglectful or Absent Parents Triggered Most Removals From Home

Neglect and caretaker absence or incapacity were the primary reasons why young children were removed from their families in both California and New York, the states where data were available. Together, these reasons accounted for approximately 47 percent and 68 percent of the removals in 1986 and 1991, respectively. No other reasons for removals,

such as physical abuse, accounted for a large portion of the entries of young children into foster care in either year. For example, all types of abuse accounted for 11 percent of the removals of young children in 1986 and 7 percent in 1991. (See fig. 2 and table II.6 in app. II.)

Figure 2: Reasons for Removal of Young Children From Home in California and New York



Note: There were other reasons for removals that did not account for significant portions of total removals. In addition, some cases only show broad service program categories, such as "court ordered placement;" others are listed as unknown or error.

[a]Includes removals due to neglect, caretaker absence or incapacity, relinquishment, and voluntary placements.

[b]Consists of physical, sexual, and emotional abuse.

[c]Consists of New York data only. This state uses up to two reasons for removal, thus, abuse and/or neglect can be cited. Further, the definitions of some reasons for removal, such as Health/Safety, refer to abuse and/or neglect.

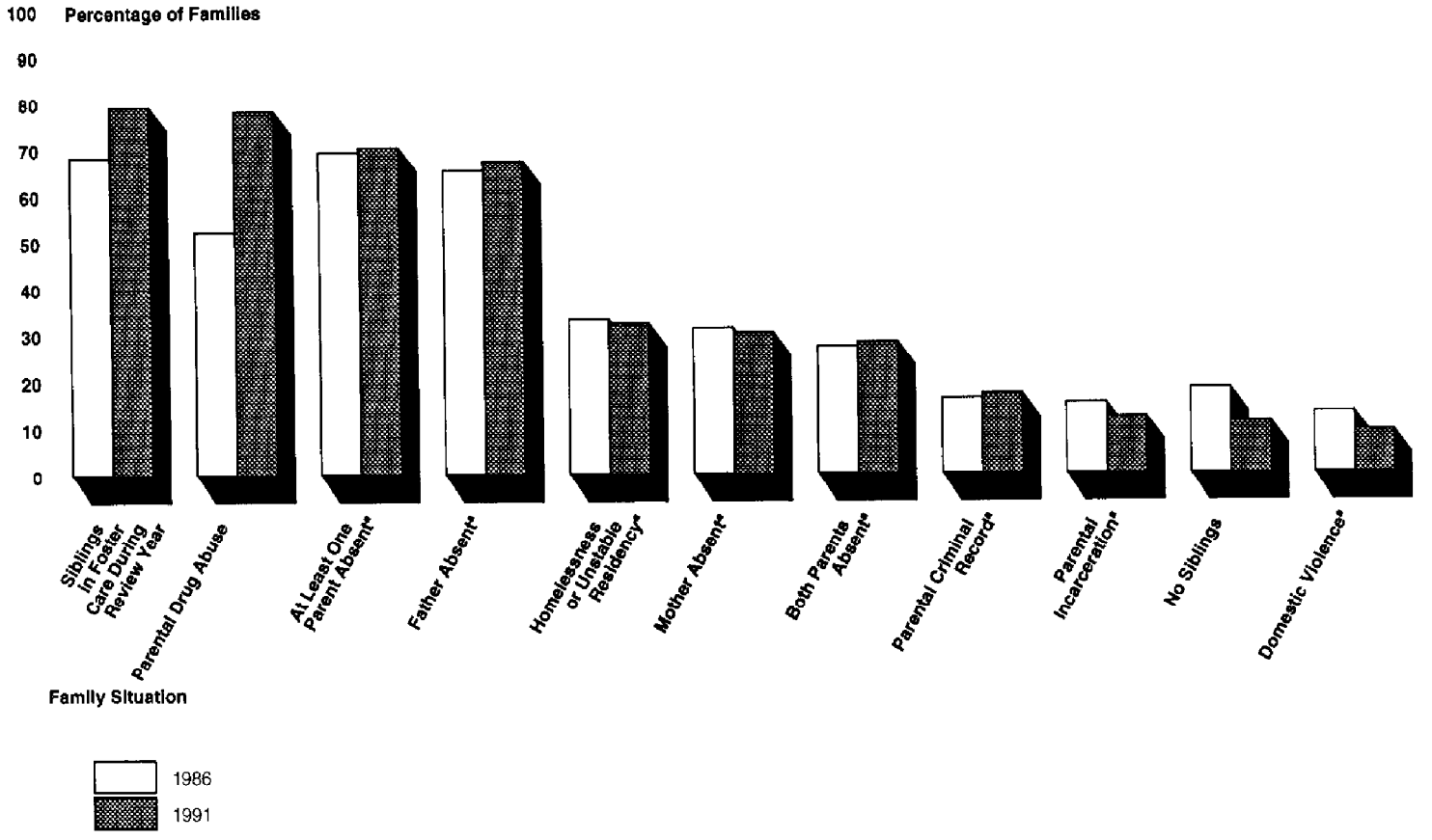
Source: State electronic databases.

Drug Abuse Further Impacts Troubled Families

To better describe the parents' situation around the time their children were removed from home, we reviewed random samples of case files for certain difficulties that families face in the three locations reviewed. Of these situations, estimated increases in the number of parents who abused drugs or had other children in foster care are significant between 1986 and 1991. Fully 78 percent of the young foster children reviewed had at least one parent who was abusing drugs or alcohol in 1991 compared with 52 percent in 1986. Families with other children in foster care increased from 68 percent to 79 percent. Further, families with no other children decreased from an estimated 18 percent to 11 percent during this time.

Families in 1991 had additional serious problems in common with their counterparts in 1986 in the three locations. For example, the percentage of young foster children who came from families with at least one parent absent was high in both years, estimated at about 70 percent. In addition, over 27 percent of the young foster children in these years came from families where both parents were absent from the home around the time of the child's removal, according to our estimates. (See fig. 3 and table II.7 in app. II.)

Figure 3: Family Situation in Three Counties



[a]Differences are not statistically significant at the 95-percent confidence level.

Source: Case file review.

The urgent need for attention to the problems that these families face is underscored by the facts that in 1991, about one-third of these families were comprised of drug-abusing single mothers and most had more than one child in foster care. Without treatment programs designed for pregnant women and mothers, women are likely to continue using drugs, leaving few alternatives to foster care for these families. Yet, as we

previously reported, access to treatment programs for pregnant women is lacking.[5]

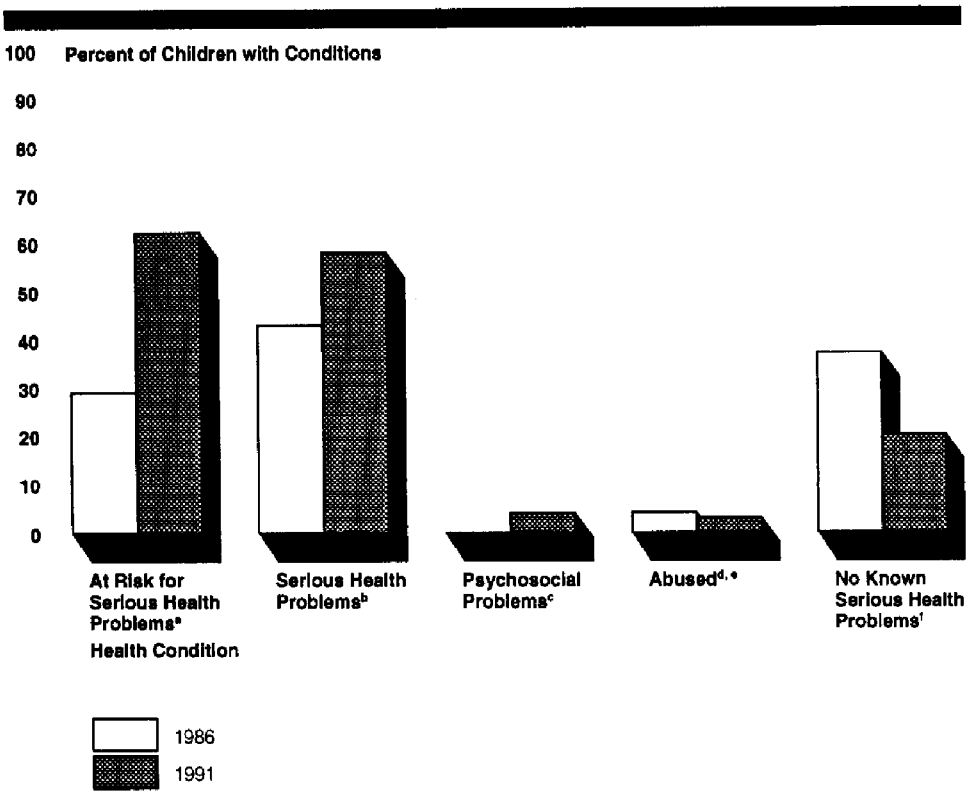
More Children Are Ill or at High Risk

Young children in foster care have or are at high risk for a wide range of health problems. In the locations reviewed, young foster children with serious physical health problems increased significantly, to an estimated 58 percent; similarly, 62 percent of them were at high risk for serious health problems due to prenatal drug exposure in 1991. The comparable estimates for 1986 were 43 percent and 29 percent, respectively.[6] (See fig. 4 and table II.8 in app. II.)

[5]ADMS Block Grant: Women's Set-Aside Does Not Assure Drug Treatment for Pregnant Women (GAO/HRD-91-80, May 6, 1991).

[6]We considered a child to be prenatally drug-exposed if any of the following conditions were documented in the child's foster care records: mother self-reported drug use during pregnancy, toxicology test results for mother or infant were positive for drug use, or infant was diagnosed as having drug-withdrawal symptoms.

Figure 4: Health Conditions of Young Foster Children in Three Counties



[a]Consists of prenatal drug exposure (including alcohol exposure) and drug withdrawal or symptoms.

[b]Consists of fetal alcohol syndrome (FAS), low birth weight, cardiac defects or heart problems, HIV positive or AIDS, developmentally delayed, and other serious problems.

[c]Consists of psychologically disturbed and behavioral problems.

[d]Consists of physical, sexual, and emotional abuse.

[e]Differences are not statistically significant at the 95-percent confidence level.

[f]Consists of children who did not have any of the above conditions. However, these children may have had minor illnesses.

Source: Case file review.

Medical research suggests that the chronic illnesses these children have or are at risk for, such as developmental delays, may have been caused or compounded by prenatal exposure to drugs and alcohol. Supportive

services and treatment beyond those needed by the average child will be required for many of them.

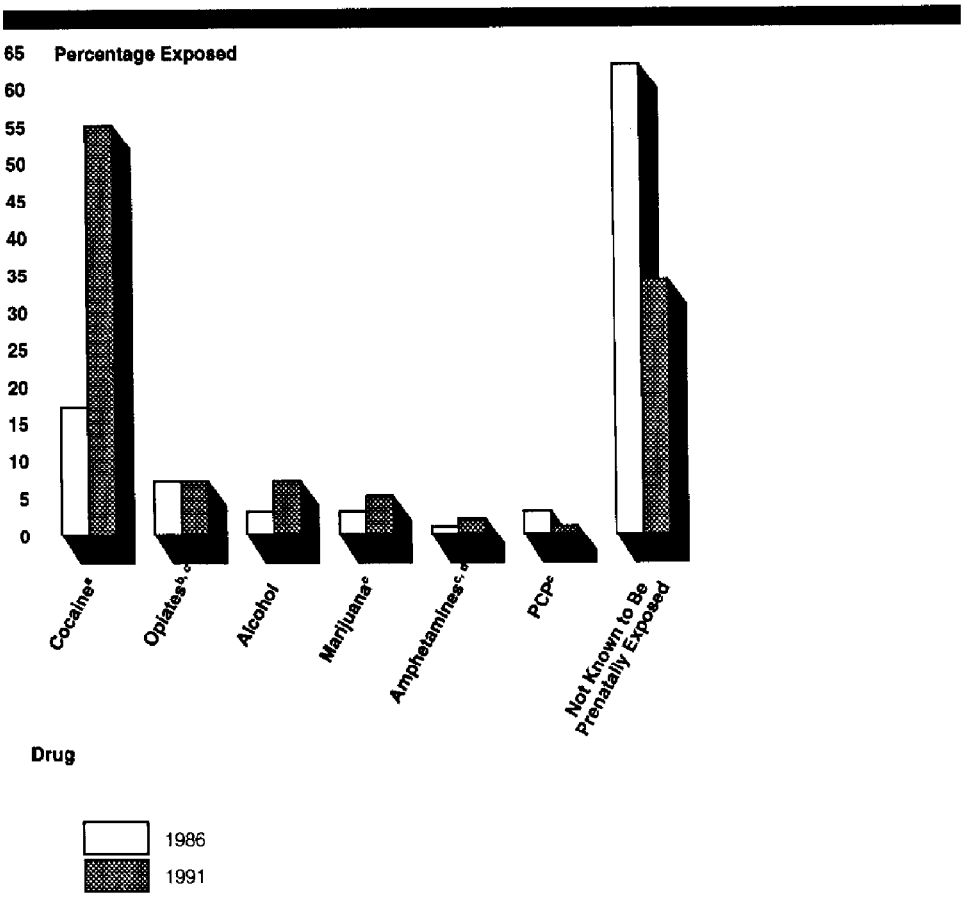
In addition, the number of drug-exposed children may be underestimated. We relied on mothers' self-reporting of drug use as well as the more objective toxicology tests. Yet, not all children or mothers are tested at birth for drugs and, when tested, only recent drug use can be confirmed. In 1991 only 59 percent of young foster children were known to have received a toxicology test at birth to determine prenatal drug exposure in the days before delivery. We previously reported that hospitals differ in their efforts to identify drug-exposed infants.[7] Further, while hospitals serving primarily Medicaid patients are more likely to perform toxicology tests than those serving primarily non-Medicaid patients, drug use during pregnancy is as likely to occur among privately insured women as among those relying on public assistance for their health care.

Cocaine Use Escalated

Cocaine was the most prevalent drug that young foster children were known to be prenatally exposed to in both years. The percentage of young foster children estimated to have been prenatally exposed to cocaine increased significantly, from 17 percent in 1986 to 55 percent in 1991. Because toxicology tests cannot identify the form of cocaine used, we often could not determine whether crack or another form of cocaine had been used; however, in some cases mothers self-reported crack use. Of the children who were prenatally drug-exposed in 1991, 24 percent of their mothers used more than one kind of drug during pregnancy. (See fig. 5 and table II.9 in app. II.)

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

Figure 5: Prenatal Drug Exposure in Three Counties



[a]Includes crack and other cocaine derivatives.

[b]Includes heroin and methadone.

[c]Differences are not statistically significant at the 95-percent confidence level.

[d]Includes methamphetamines.

Source: Case file review.

The increased use of cocaine by the mothers of young foster children adds additional urgency to the need for drug treatment programs if the impact of drug abuse on foster care is to be alleviated. Studies have found that prenatal cocaine exposure can be addictive and can result in withdrawal symptoms, direct injuries, and disabling effects on developing fetuses. When the crack derivative of cocaine is used, the user can become

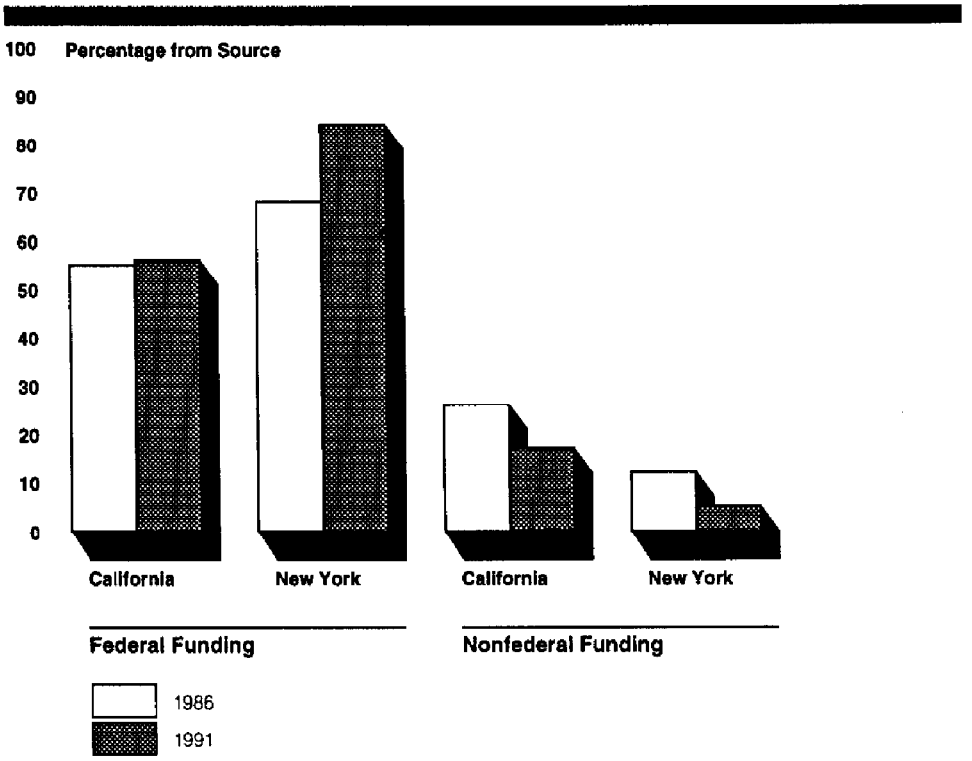
addicted much more quickly and the effects of the exposure on the fetus are more severe. We previously reported that researchers attribute crack's popularity among women to its low cost and the users' perception that smoking a drug is more acceptable and less intrusive than injecting one.[8] Further, we reported that a study of prostitutes found that cocaine and crack users are as likely as intravenous drug users to test positive for the human immunodeficiency virus (HIV) that causes AIDS. Other research has found that mothers who abuse cocaine are likely to have three to five children. Thus, cocaine-abusing women may have a greater impact on both the foster and health care systems than users of other drugs.

Foster Care Costs Increased

A greater portion of foster care maintenance expenditures for young children shifted to the federal government between 1986 and 1991, compounding the impact of the increase in overall foster care maintenance costs. Much of the 110-percent growth in the population of young foster children between 1986 and 1991 occurred among those who were AFDC-eligible for federal matching funds, thereby placing even greater financial responsibility on the federal level. (See fig. 6 and table II.10 in app. II.)

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

Figure 6: Sources of Foster Care Maintenance Funding in California and New York



Source: State electronic databases.

For the three states reviewed—California, New York, and Pennsylvania—total foster care maintenance expenditures, including both state and federal portions, increased from about $848 million in 1986 to over $2 billion in 1992.[9] In 1992, foster parents of young children received a minimum monthly payment of $345 in California, $353 in New York, and $330 in Pennsylvania. However, foster parents can receive much higher payments to care for children with special needs. For example, in New York City, foster parents caring for very sick children can be paid as much as $1,281 per month for each child in their care. Further, if foster children require specialized care in a group setting, maintenance payments could be even higher; for example, the maximum monthly payment is $4,762 in Los Angeles County.

[9]No national data exist on total costs for foster care.

We conducted our work between November 1992 and November 1993 in accordance with generally accepted government auditing standards. Our scope and methodology are discussed further in appendix I. As agreed with your office, we did not obtain written comments on this report, but discussed its contents with state and county program officials in California, New York, and Pennsylvania and officials from HHS. We incorporated their comments where appropriate.

In addition, unless you publicly announce its contents earlier, we plan no further distribution of this report until 21 days after its issue date. At that time, we will send copies to the Secretary of Health and Human Services, the Attorney General, the Director of the Office of National Drug Control Policy, program officials in the states reviewed, and other interested parties. We will also make copies available to others upon request. For additional information, please call me on (202) 512-7215. Major contributors to this report are listed in appendix III.

Sincerely yours,

Jane L. Ross

Jane L. Ross
Associate Director
Income Security Issues

Contents

Figures

Abbreviations

AIDS	acquired immune deficiency syndrome
AFDC	Aid to Families with Dependent Children
EPSDT	early and periodic screening, diagnosis, and treatment
FAS	fetal alcohol syndrome
HHS	Department of Health and Human Services
HIV	human immunodeficiency virus
LSD	lysergic acid diethylamide
PCP	phencyclidine hydrochloride

Scope and Methodology

To accomplish the objectives of our review, we obtained and analyzed data on state foster care programs and the children in them from the three states with the largest average monthly foster care populations in 1991—California, New York, and Pennsylvania. Over 50 percent of the nations's foster children are under the jurisdiction of the three states we reviewed.

We used a variety of approaches to meet our objectives. We analyzed electronic state and county foster care databases; conducted a case file review based on generalizable random samples; interviewed Department of Health and Human Services, state, and county foster care officials; conducted a telephone survey of child welfare advocacy groups and other child welfare experts; conducted group interviews with foster parents and case workers; reviewed foster care and related literature; reviewed applicable portions of the Social Security Act and other legislation; and reviewed foster care agency regulations and other documents.

Statewide Data

To determine the foster care population size, reasons for removal, and funding eligibility of young foster children, we analyzed electronic foster care databases for states where they were available, California and New York. State officials provided us with automated records for all children who were in foster care at any time during calendar years 1986 and 1991.

We could not obtain comparable electronic records for Pennsylvania as that state has not established an automated case record system. Instead we relied on aggregate data available in management reports for 1986 and 1991 to determine the size of the state foster care population. Thus, we relied on end-of-year data, which undercounts the total foster care population for that state.

To determine the population size for all children in the three states, we used 1986 and 1991 Bureau of the Census midyear estimates.

County Case File Data

To determine additional characteristics of young foster children, we reviewed statistically representative samples of foster care case files for the county with the largest foster care population in 1991 for each of the states reviewed. To identify those locations, we again used the state foster care databases for California and New York; for Pennsylvania, we relied on information provided by state officials. The counties identified are Los

Angeles County, New York City, and Philadelphia County, respectively.[1] To complete our sampling, Philadelphia County officials provided us with an electronic database of foster children in that county in 1986 and 1991. Table I.1 shows the number of children in that county whose electronic records were initially supplied to us by county officials and the final number of children whose records remained after we expunged records that did not meet our criteria because they were for children who were in emergency homeless shelters, not foster care.

Table I.1: Initial and Final Population Sizes for Philadelphia County's Electronic Database of Children in Foster Care

	1986		1991	
	Initial size	Final size	Initial size	Final size
Philadelphia County database	8,852	7,405	8,885	7,704

Before drawing the sample, we narrowed the databases to include only foster children whose third birthday occurred no later than December 31 in the year under review. In addition, we stratified the foster care records of the 32,123 young foster children in our population by location and by year. Our initial samples contained 932 children. The population and initial sample sizes are shown in table I.2.

Table I.2: Initial Population and Sample Sizes for Children in Foster Care

	1986		1991	
	Population	Sample	Population	Sample
Los Angeles County	4,241	226	8,249	137
New York City	4,381	150	13,171	150
Philadelphia County	746	142	1,335	127
Total[a]	**9,368**	**518**	**22,755**	**414**

[a]Sample size totals are provided to indicate the composition of the initial samples. When used in analyses, sample strata were weighted.

We requested all foster care case files for each child in the samples. A few case files were dropped from the samples because the child did not meet the criteria of being in foster care during the review year or was not of the appropriate age. In addition, other case files were dropped because county officials could not locate them. In particular, for one county, many of the 1986 case files we requested could not be found. By comparing demographic data for available and unavailable case files in that county, we determined that the two groups had similar characteristics. Further, state and county program officials told us that they are unaware of

[1]New York City is comprised of five boroughs and is treated in the state database as a county.

differences between the available and unavailable case files and believe that they represent the same population. We concluded that the dropped case files were likely to be analogous to those we reviewed. Thus, we used them for comparisons with 1991.

Our final sample size was 759 young foster children. We used an adjusted population size, inversely proportional to our dropout rate, to project to the county level; however, the data cannot be projected to these states as a whole or to the national population of foster children. Initial and final sample sizes, along with the percentages of the initial samples used, are shown in table I.3.

Table I.3: Sample Sizes and Percentages of Initial Samples Used

	Initial sample	Final sample	Percent of initial sample used
1986			
Los Angeles County	226	132	58.4
New York City	150	131	87.3
Philadelphia County	142	113	79.6
Total[a]	**518**	**376**	**73.6**
1991			
Los Angeles County	137	122	89.1
New York City	150	145	96.7
Philadelphia County	127	116	91.3
Total[a]	**414**	**383**	**93.6**

[a]Percentage totals are weighted averages showing the percentage of the total population covered by the final samples.

We examined the foster care case files beginning at a child's first entry into foster care until the end of the review year or until the child was discharged from foster care, whichever occurred earlier. We used an automated data collection instrument to record information from the case files. The recorded information was reviewed for accuracy by the individual preparing it before finalizing each electronic record. We also reviewed the case file data for consistent coding among individuals; minor adjustments were made to the coding as a result of that review.

We analyzed the case file data using univariate analysis, a descriptive statistical method. We also used a t-test to determine statistically significant differences between the 1986 and 1991 data. In addition, when

combining the strata, we weighted them to adjust for disproportionate sampling. Finally, we found that results from the three locations were similar; thus, the locations could be combined for analysis.

For data derived from the case file review, the percentage estimates reported in the letter and the numerical estimates reported in appendix II are point estimates. The precision of these estimates varies with the quantitative relationship of a number of attributes in a population. We are 95-percent confident that the point estimates fall within the confidence intervals reported in appendix II. Conversely, there is a 5-percent chance that the confidence intervals do not contain the actual population.

We performed limited tests of the completeness of the case files. However, we did not independently verify the accuracy of the electronic databases provided to us by state and county officials.

Distinctive Characteristics Analysis Results

This appendix presents the numerical values for the data discussed in the body of this report. Where appropriate, point estimates and confidence intervals are provided. The appendix includes statewide data and case file review results for the review years of 1986 and 1991.

Table II.1: All Children in Foster Care in Three States

	1986	1991	Percent change
California[a]	70,240	109,804	56.3
New York[a,b]	44,613	84,997	90.5
Pennsylvania[c]	13,181	17,737	34.6
Total	**128,034**	**212,538**	**66.0**

[a]California and New York counts of foster children represent all children who were in foster care at any time during the review year.

[b]Part of New York's increase in foster children is due to the provisions of the New York Supreme Court case, Eugene F., which required all foster children placed with relatives to be included in foster care caseloads and eligible for services.

[c]Pennsylvania's count of foster children represents year-end counts, as data on the total number of children in foster care at any time during the year were not available.

Sources: California and New York—state databases; Pennsylvania—aggregate state data.

Table II.2: Young Children in Foster Care in Three States

	1986	1991	Percent change
California[a]	10,039	18,786	87.1
New York[a,b]	6,443	16,215	151.7
Pennsylvania[c]	2,341	4,537	93.8
Total	**18,823**	**39,538**	**110.1**

[a]California and New York counts of foster children represent all young children who were in foster care at any time during the review year.

[b]Part of New York's increase in foster children is due to the provisions of the New York Supreme Court case, Eugene F., which required all foster children placed with relatives to be included in foster care caseloads and eligible for services.

[c]Pennsylvania's count of young foster children represents year-end counts, as data on the total number of young children in foster care were not available. Further, that count is for foster children under the age of 5 years, as its aggregate data did not break out children under age 3 years.

Sources: California and New York—state databases; Pennsylvania—aggregate state data.

Table II.3: All Children in Three States

	1986	1991	Percent change
California	7,044,750	8,172,768	16.0
New York	4,341,069	4,359,573	0.4
Pennsylvania	2,840,991	2,825,376	-0.5
Total	**14,226,810**	**15,357,717**	**7.9**

Source: Bureau of the Census midyear estimates.

Table II.4: Young Children in Three States

	1986	1991	Percent change
California	1,320,377	1,671,335	26.6
New York	730,588	828,255	13.4
Pennsylvania	465,077	491,742	5.7
Total	**2,516,042**	**2,991,332**	**18.9**

Source: Bureau of the Census midyear estimates.

Table II.5: States' Young Children in Foster Care in Three Counties

	1986 populations			1991 populations		
	State foster care	Selected county foster care	Percent of state foster care	State foster care	Selected county foster care	Percent of state foster care
California[a]	10,039	4,241	42.2	18,786	8,249	43.9
New York[a]	6,443	4,381	68.0	16,215	13,171	81.2
Pennsylvania[b]	2,341	746	31.9	4,537	1,335	29.4
Total	**18,823**	**9,368**	**49.8**	**39,538**	**22,755**	**57.6**

[a]California and New York counts of foster children represent all young children who were in foster care at any time during the review year.

[b]Pennsylvania's state count of young foster children represents year-end counts, as data on the total number of young children in foster care at any time during the year were not available. Further, that count is for foster children under the age of 5 years, as its aggregate data did not break out children under age 3 years. However, the count for the selected county represents all children under age 3 years who were in foster care at any time during the year.

Sources: California and New York—state databases; Pennsylvania—aggregate state data and county database.

Table II.6: Reasons for Removal of Young Children From Home in California and New York

	1986			1991		
	Neglect[a]	Abuse[b]	Abuse and/or neglect[c]	Neglect	Abuse	Abuse and/or neglect
California	4,259	1,844	•	15,340	2,495	•
New York	3,524	14	1,028	8,497	17	1,522
Total	**7,783**	**1,858**	**1,028**	**23,837**	**2,512**	**1,522**

Note: There were other reasons for removals that did not account for significant portions of total removals. In addition, some cases only show broad service program categories, such as "court ordered placement," and others are listed as unknown or error.

[a]Includes removals due to neglect, caretaker absence or incapacity, relinquishment, and voluntary placements.

[b]Consists of physical, sexual, and emotional abuse.

[c]Consists of New York data only. This state uses up to two reasons for removal, thus, abuse and/or neglect can be cited. In addition, the definitions of some reasons for removal, such as Health/Safety, refer to abuse and/or neglect.

Sources: State databases.

Table II.7: Family Situation Around the Time of Removal From Home in Three Counties

Situation	Statistically significant change[a]	1986 Point estimate, number	1986 Point estimate, percent	1991 Point estimate, number	1991 Point estimate, percent	Confidence interval at 95-percent confidence level: 1986 Upper bounds, percent	1986 Lower bounds, percent	1991 Upper bounds, percent	1991 Lower bounds, percent
Social Problems									
Drug abuse	yes	3,572	51.8	16,660	78.2	58.0	45.6	83.4	73.0
Criminal record	no	1,132	16.4	3,604	16.9	20.7	12.7	20.7	13.5
Incarcerated	no	1,037	15.0	2,587	12.1	19.0	11.0	15.7	8.6
Homeless[b]	no	2,305	33.4	6,809	32.0	39.0	27.9	37.4	26.5
Domestic violence	no	867	12.6	1,989	9.3	16.5	9.2	12.9	6.4
Divorced	no	0	0.0	60	0.3	1.8	0.0	2.2	0.0
Parents absent									
At least one parent absent	no	4,754	68.9	14,828	69.6	75.3	62.6	75.3	64.0
Father absent	no	4,512	65.4	14,353	67.4	71.8	59.1	73.1	61.7
Mother absent	no	2,125	30.8	6,454	30.3	36.3	25.4	35.6	25.0
Both parents absent	no	1,883	27.3	5,978	28.1	32.5	22.1	33.3	22.9
Deceased	no	96	1.4	570	2.7	3.8	0.5	5.4	1.3
Siblings									
Siblings in foster care in review year	yes	4,659	67.5	16,790	78.8	73.7	61.4	83.9	73.8
Siblings not in foster care in review year	no	667	9.7	1,608	7.6	12.7	6.6	10.5	4.6
No siblings	yes	1,242	18.0	2,357	11.1	22.4	13.7	14.7	7.5

[a]Statistically significant change between 1986 and 1991.

[b]Includes unstable residency.

Source: Case file review.

Table II.8: Health Conditions of Young Foster Children in Three Counties

						Confidence interval at 95-percent confidence level			
		1986		1991		1986		1991	
Health conditions	Statistically significant change[a]	Point estimate, number	Point estimate, percent	Point estimate, number	Point estimate, percent	Upper bounds, percent	Lower bounds, percent	Upper bounds, percent	Lower bounds, percent
At risk for serious health problems[b]	yes	1,996	28.9	13,290	62.4	34.2	23.7	68.2	56.6
Drug-exposed	yes	1,799	26.1	13,202	62.0	31.1	21.1	67.8	56.2
Drug-exposed (excludes alcohol)	yes	1,746	25.3	12,786	60.0	30.3	20.4	65.9	54.2
Alcohol-exposed (excludes drugs)	yes	176	2.6	1,198	5.6	5.1	1.3	8.7	3.2
Drug withdrawal	yes	1,171	17.0	5,936	27.9	21.6	12.4	33.2	22.6
Serious health problems[c]	yes	2,977	43.2	12,420	58.3	49.1	37.2	64.1	52.5
Fetal alcohol syndrome	no	77	1.1	257	1.2	3.5	0.3	3.5	0.4
Low birth weight	yes	985	14.3	5,084	23.9	18.3	10.2	28.9	18.9
Heart problems	no	409	5.9	1,786	8.4	9.2	3.8	12.0	5.0
HIV or AIDS	no	0	0.0	383	1.8	1.8	0.0	4.3	0.6
Developmentally delayed	yes	546	7.9	3,753	17.6	11.0	4.9	22.0	13.2
Other	yes	2,352	34.1	10,119	47.5	39.7	28.5	53.3	41.7
Abused[d]	no	243	3.5	569	2.7	6.2	2.1	5.3	1.4
Physical	no	175	2.5	509	2.4	5.1	1.5	5.0	1.2
Sexual	no	56	0.8	60	0.3	2.9	0.2	2.2	0.0
Emotional	no	29	0.4	0	0.0	2.5	0.0	1.8	0.0
Psychosocial problems[e]	yes	11	0.2	833	3.9	2.0	0.0	6.9	2.1
Psychologically disturbed	no	0	0.0	236	1.1	1.8	0.0	3.4	0.3
Behavioral problems	yes	11	0.2	773	3.6	2.0	0.0	6.6	1.9
No known serious health problems[f]	yes	2,543	36.9	4,162	19.5	42.5	31.2	24.1	15.0

(Table notes on next page)

[a]Statistically significant change between 1986 and 1991.

[b]Consists of prenatal drug exposure (including alcohol exposure) and drug withdrawal or symptoms.

[c]Consists or fetal alcohol syndrome (FAS), low birth weight, cardiac defects or heart problems, HIV positive or AIDS, developmentally delayed, and other serious problems.

[d]Consists of physical, sexual, and emotional abuse.

[e]Consists of psychologically disturbed and behavioral problems.

[f]Consists of children who did not have any of the above conditions. However, these children may have had minor illnesses.

Source: Case file review.

Table II.9: Prenatal Drug Exposure in Three Counties

Prenatal drug exposure	Statistically significant change[a]	1986 Point estimate, number	1986 Point estimate, percent	1991 Point estimate, number	1991 Point estimate, percent	Confidence interval at 95-percent confidence level: 1986 Upper bounds, percent	1986 Lower bounds, percent	1991 Upper bounds, percent	1991 Lower bounds, percent
Cocaine[b]	yes	1,185	17.2	11,642	54.7	21.8	12.6	60.8	48.5
Alcohol	yes	230	3.3	1,509	7.1	6.1	1.9	10.4	4.5
Marijuana	no	203	2.9	1,028	4.8	5.5	1.7	7.8	3.1
Opiates[c]	no	496	7.2	1,551	7.3	10.5	5.0	10.7	4.9
Amphetamines[d]	no	96	1.4	361	1.7	3.5	0.6	4.0	0.7
PCP	no	225	3.3	301	1.4	5.7	1.9	3.6	0.5
Tobacco	no	152	2.2	181	0.8	4.8	1.1	3.0	0.2
LSD	no	0	0.0	0	0.0	1.8	0.0	1.8	0.0
Not known to be prenatally exposed	yes	4,363	63.3	7,289	34.2	69.4	57.1	39.7	28.8

[a]Statistically significant change between 1986 and 1991.

[b]Includes crack and other cocaine derivatives.

[c]Includes heroin and methadone.

[d]Includes methamphetamines.

Source: Case file review.

Table II.10: Sources of Foster Care Maintenance Funding in California and New York

	1986 Federal funding	1986 Nonfederal funding	1991 Federal funding	1991 Nonfederal funding
California	5,496	2,572	10,487	3,245
New York	4,384	751	13,649	738
Total	**9,880**	**3,323**	**24,136**	**3,983**

Sources: State databases.

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