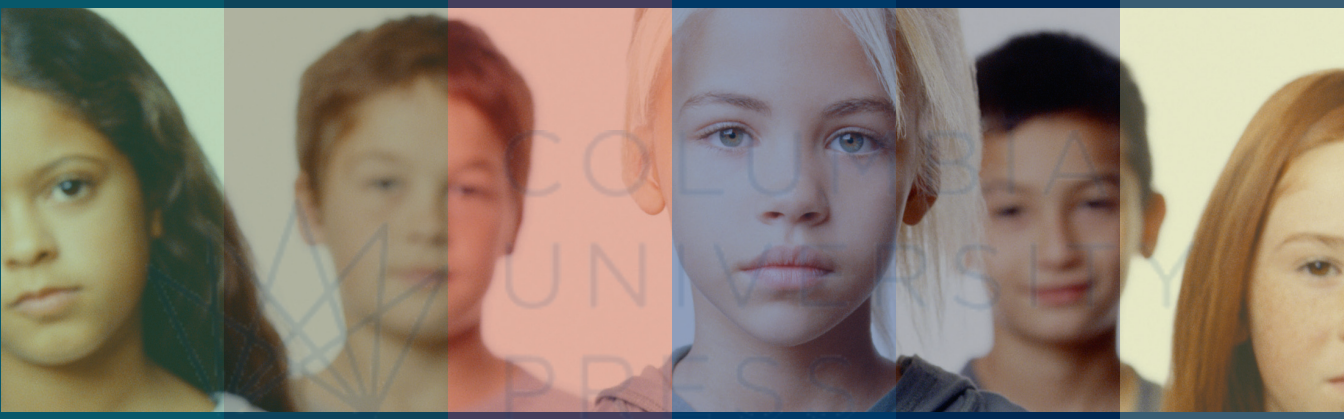
Critical Issues in Child Welfare



Joan Foster Shireman

SECOND EDITION

CRITICAL ISSUES IN CHILD WELFARE

FOUNDATIONS OF SOCIAL WORK KNOWLEDGE

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Frederic G. Reamer, Series Editor

Social work has a unique history, purpose, perspective, and method. The primary purpose of this series is to articulate these distinct qualities and to define and explore the ideas, concepts, and skills that together constitute social work's intellectual foundations and boundaries and its emerging issues and concerns.

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To my beloved grandchildren,
David and Andrew, Erika and Christopher,
Amy and Sally, and to all the young people
who are our future.

❖ CONTENTS

❖ ACKNOWLEDGMENTS

This book is the sum of many years of reading, teaching, research, direct service, and conversation concerning child welfare and its many issues. It would not be possible to acknowledge all who have contributed to it. Students—with their questions, observations, and demands for social justice—have been important in its formation. It was in this interaction with students, while teaching from the first edition of the book, that I began to realize how much was changing in the field of child welfare and how a second edition would have value.

It was my good friend Frederick Reamer who suggested the possibility of the first edition of the book and whose encouragement was important in a decision to create a second edition. Katharine Cahn, Karen Tvedt, and Miranda Cunningham generously contributed their ideas as coauthors of three chapters. Kenneth Watson was kind enough to critique the chapters on out-of-home care, John Triseliotis the chapter on adoption: I mourn their passing and note that their excellent suggestions remain firmly embedded in those chapters. Conversations with Diane Yatchmenoff and the thoughtful staff of a five-year research project (described in the introduction) grounded the book in the practice world of child welfare. Tamara Kincaid and Jennifer Bellamy reviewed the book and improved it enormously with suggestions from their different perspectives, and to them I owe many thanks. Editors at Columbia University Press have consistently been helpful as these two editions evolved. I also want to acknowledge my colleagues at Portland State University, whose support was important in the completion of the books, and the support of good friends and family, who cheered me on when the task seemed long.

Finally, I want to acknowledge the contribution of my husband, Charles Shireman. The memory of his thoughtful scholarship, ethical decision making, and dedication to social justice has guided my thinking as this edition took shape. I hope this book reflects his high standards for social work practice.

❖ ACRONYMS

Acronyms are handy and also can be mystifying. Following are some that are frequently used in the text.

ACES	Adverse Childhood Experiences Study
AFCARS	Adoption and Foster Care Analysis and Reporting System
ASFA	Adoption and Safe Families Act of 1997
CAPTA	Child Abuse Prevention and Treatment Act of 1974
CASA	Court Appointed Special Advocate
CFSR	Child and Family Services Review
CHIP	Child Health Insurance Program
ICWA	Indian Child Welfare Act
IEP	Individual Educational Plan
MEPA	Multiethnic Placement Act of 1994
NCANDS	National Child Abuse and Neglect Data System
NIS	National Incidence Study of Child Abuse and Neglect. Fourth study is referred to as NIS-4
NSCAW	National Survey of Child and Adolescent Well-Being
SACWIS	State Automated Child Welfare Information System
SNAP	Supplemental Nutrition Assistance Program (also known as food stamps)
TANF	Temporary Assistance to Needy Families
WIC	Special Supplemental Nutrition Program for Women, Infants, and Children

CRITICAL ISSUES

IN CHILD WELFARE

Introduction: Social Work and Child Welfare

Child welfare is a specialized field of practice within which the values and skills of social work are implemented. Historically, the fields of child welfare and social work have been intertwined—sometimes almost the same field, as at the time of the founding of the juvenile courts and the Children's Bureau, but at other times distinct. In 2003, when the first edition of this book was published, it was one of those times when child welfare was distinct from social work. Child welfare was working under a narrow definition as a specialized field with a focus on the protection of children. Social work was just beginning its movement away from emphasis on therapeutic interventions and mental health. However, in the past ten years, child welfare has begun to shift its focus to a broad concept of the welfare of children and families. And social work seems to be resuming its historical thrust toward social justice.

The definition of child welfare is important. Some basic principles will make clear the point of view from which this book is written.

- There is no dichotomy between the welfare of the child and the welfare of the family. Every child grows best in his or her own family if the family can provide proper care. Any policy that supports family life supports the welfare of children. Child welfare is, therefore, about the welfare of children and families.
- Many children are growing up in severely stressed families. For some children (approximately nine out of every thousand), concerns about safety within the family are established (U.S. Department of Health and Human Services 2013). Work with these children and their families requires a special set of skills that are unique to the practice of child welfare. Protective service requires the ability to assess family strengths and risks to the child. It requires the skills to help families use their strengths to care adequately for their children. Out-of-home placement requires the ability to assess the needs of the child and the strengths of various placement options, matching the two. It also requires knowledge of the meaning of separation to the child and the ability to work with children to minimize trauma.
- The development of children who enter the child welfare system often has been severely distorted by their prior experiences and, if they are placed in out-of-home care, by the trauma of separation from their families. Brain-imaging technology is revealing the neurologic damage to children resulting from these experiences. Multiple community resources will be involved in providing for these children and youth. Parents, foster parents, and residential care providers have daunting challenges. Consistency and stability of care are critical.
- Skills needed to work with these children and their families, to stabilize out-of-home placements, and to preserve children's connections to family are of a high order and demand a professional educational background, as well as training in specific

skills. The congruence between child welfare and social work knowledge and value bases, as well as a long history, has made social work education a preferred background for child welfare practitioners.

The definition of child welfare used in this book thus encompasses the set of community-supported programs that enhance the welfare of children—a broad definition, but one that must be constantly in the minds of those who are advocates for children. The goals of child welfare—safety, a permanent family, and well-being for every child—are the goals of all of these programs. This book describes those programs that directly enhance the ability of families to care for their children—preventing, remedying, or ameliorating maltreatment—and are within the realm of social work services. For practical reasons only, educational, recreational, and medical services receive little attention in this book, though all of these are part of a comprehensive system of services to children and families.

As an overview of the field of child welfare, this book is written to help those working with children and families, or preparing for this work, to attain an acquaintance with child welfare policy and with the research and practice issues that inform it. The student will find a focus on the role that social work can and should play in child welfare services. It is a policy book, not a book about practice. But the two cannot really be separated, for policy shapes practice, and practice shapes policy. And both should be informed by theory, empirical work, and practice wisdom.

Child welfare services are firmly embedded in their communities. This book begins with a look at the community context of child welfare, noting changes over time, and the role of social work in the development of services to children and families. In chapter 1, the focus is on the problems that children and families face. Next, in chapter 2, the framework for child welfare services is outlined, including the goals and key outcomes expected. The remaining chapters provide an overview of the core services of child welfare.

The book encompasses a vast array of information and necessarily includes only superficial description of some important elements of the system. However, at the end of each chapter, the reader will find a section in which a critical issue is identified and explored in some depth. Poverty seems to be the critical issue of all child welfare, the condition that shapes the lives of far too many children and families, thus it is the first of the issues to be discussed in depth at the end of chapter 1. The critical issues of chapters 2, 3, and 5—building of lifelong family connections as an outcome of services, the disproportionate representation of children of color in the child welfare system, and the developing empirical base for child welfare services—are fundamental concerns throughout child welfare services. The critical issue of chapter 4 is early care and education, increasingly important as we learn more about the lifelong impact of early child development. Beyond these fundamental issues, the critical issues discussed in the other chapters are more specific, but central to the topic of each chapter: establishing and retaining foster homes, long-term outcomes of out-of-home care, adoption outcomes and post-adoption services, and the transition from child welfare services to adult living. The final critical issue discussed in depth is the retention of workers, vital to the delivery of services. These issues were chosen because they are of central importance to child welfare today and are currently the focus of research and development of policy and services. The selection of these issues will, however, be controversial; the reader might well have selected others.

The Crisis in Child Welfare

Those child welfare services that enhance the growth and development of children in their own families tend to be valued by the community. These are services designed to support family life, such as early child care and

education, respite care, parenting classes, and counseling programs that help troubled parent-child relationships. These are services into which most families enter voluntarily. Many are underfunded. Some have had their efficacy demonstrated; the effectiveness of others has yet to be ascertained. The array of available services continually changes as families, communities, and legislatures experiment with what can be funded, what can be sustained, and what is useful. There is great variability in the availability of these services, particularly between urban and rural areas. These services face important challenges: how to expand successful, small demonstrations to serve larger populations; how to target services accurately so as to prevent later, larger problems; and how to secure and maintain funding.

Whereas such family-based and community-supported programs are challenged, public child welfare services are experiencing a crisis. The crisis is most acute in protective services and in foster care, although other parts of the child welfare system have their controversies and uncertainties. The reasons for the crisis in child welfare are not complex. Higher community standards for the care of children coupled with deterioration of family stability and community cohesiveness has created an overwhelming number of referrals of children thought to be in need of protection—in 2012 an estimated 3.4 million referrals (U.S. Department of Health and Human Services 2013). A legacy of forty years of unwillingness to fund children's services, or any social services, at a generous level has left public child welfare agencies with staffs that, in general, are not professionally educated and are managed by an intricate network of policy directives. The complex decisions that must be made in working with families and children under stress can overwhelm untrained workers, so that resignations and new hiring compound the problems of the child welfare agencies.

Overwhelmed by the numbers of children and families needing help, public child welfare in the last quarter of the twentieth century narrowed its mission and focused on the protection of children, abandoning the range of services that meet the varied needs of children in many circumstances. Other community agencies, however, did not replace services once publicly funded. Only in the past ten years has public child welfare begun to expand this focus and invest in a broader range of services to families.

What happens next is not clear. As the focus of service widens to include the range of services families need, the numbers of families needing help with complex problems and the numbers and skills of child welfare workers remain unbalanced. The current expansion of the focus of services has expanded the role of the protective service worker. Positive though this broadening is for families and children, whether it can be sustained is uncertain. It is an exciting time to be involved in child welfare.

Despite a developing interest in services to preserve the families of children and prevent out-of-home placement, foster care has remained a staple of child welfare services. At the same time, demographic changes in family structure, particularly the entry of women into employment out of the home, have resulted in fewer foster homes. There may not be enough homes to match children's needs and foster families' strengths. Child welfare workers have neither the time nor skills to provide supportive help to foster families in their care of children. Too often, when problems arise, children are removed from one foster home and placed in another. The problems of the children's families of origin are complex, and change is often slow and erratic, so it takes time to move children out of foster care and back into their own homes. Long stays, with multiple moves, are damaging to children and intensify the shortage of foster homes.

Reform ideas for the foster care system have focused on reducing the number of children who need foster care, so that there would be enough foster homes. Family preservation programs and kinship foster care are the chief strategies. Other initiatives would increase the supply of foster homes through legislative limits

on the time a child can remain in foster care and through development of resources to retain foster parents in the system.

What do children from troubled families need? Primarily, they need safety, permanent, nurturing families, and continued concern for their well-being across the domains of their lives. These are the desired outcomes for child welfare services. There are a thousand different ways to achieve these goals for children; indeed, each child's unique situation calls for a unique approach. Investing in professionally trained child welfare workers, and then freeing them to use their skills while supporting them in their efforts, is one route to meeting the many individual needs of the children who come to the attention of the child welfare system. Though child welfare is an arena where many disciplines have important contributions to make, social work—with its focus on communities, family systems, and development throughout the life span and with its tradition of advocacy for the vulnerable—has particular value.

Child Welfare and Social Work: A Historical Connection

Child welfare has historically been a part of the social work profession. The early leaders in social work were deeply concerned about children and tireless in their advocacy for child labor laws, universal education, income maintenance, and other reforms that have benefited children. The interaction of social work and child welfare is documented in *Women and Children First: The Contribution of the Children's Bureau to Social Work Education* (Lieberman and Nelson 2013). Imbued with a value system that emphasizes advocacy for the powerless in our society, social workers have long espoused the interests of children and their families. The advocacy of social workers, over time, is reflected in the following quotations.

> Nor, unfortunately, does there seem to be any reason for thinking that charities for caring for destitute, neglected, and delinquent children will soon become unnecessary. We learn to deal more and more wisely with those who are in distress, but the forces which produce poverty, neglect, and crime seem to be beyond our reach. The poor, the neglectful, and the vicious we shall have with us for a long time to come, and the hearts of the generous will continue to respond, both through individual and associate charity, and through governmental action. (Folks 1902:246)

> We must also recognize that the co-morbidity of poverty, substance abuse, domestic violence, mental health issues, problems of maternal and child health, developmental disabilities, and child placement has been established beyond a reasonable doubt, and that service systems must address these multiple problems in a coordinated way if they are to meet the needs of clients. (Meezan 1999:17)

> In 2012 the United States finds itself in conditions similar to those of a century earlier, with a slow, recovery from the Great Recession, a shift from an industrial to an information/service economy, a crumbling infrastructure, large numbers of immigrants, huge wealth and income disparities, inferior public education, and 15% of the population with 22% of the children living in poverty in 2010 [Addy and Wright, as cited in Ellert]. Sadly, it seems, history has a way of repeating itself. Without a vision for the future and a reallocation of resources, maltreated children and their families will predictably experience poorer physical and mental health, remain undereducated, lack for skills, and remain dependent on an increasingly politicized society. (Ellert 2013: ch. 11)

Social Work

Social work has had a complex history. The early social welfare workers focused their efforts on reform of a society to give the poor and vulnerable greater opportunity. Specht and Courtney in their provocative book outline a history of a shift in social work from community concerns and advocacy for community change to a fascination with psychotherapy and change within the individual.

> It appears that throughout this century social work has been evolving toward a manifest destiny. Starting as the Cinderella of professions, left for years by psychiatry and psychoanalysis to do society's dirty work of tending to the poor and destitute, social work has finally been transformed into a princess. Sparklingly attired by her fairy godfather, Carl Rogers, she is off to dance at the psychotherapeutic ball with all of the other fifty-minute-hour professionals. Neither war, nor depressions, nor massive social upheavals have stayed her from her course. (Specht and Courtney 1997:163–64)

A profession is based on underlying constructs that "provide direction for the knowledge base, give a specific value orientation, and suggest research programs" (Kreuger 1997:22). Grounding in theory the dichotomy identified by Specht and Courtney, Kreuger identifies the "grand narratives" of social work as the theories of Karl Marx, which identified the victimization of the economically disadvantaged, and the theories of Sigmund Freud, which laid the groundwork for interventions that might enhance an individual's ability to cope with the world. Kreuger suggests that although these "grand narratives" have been discredited, they still form the base of social work. It is immediately apparent that the two "grand narratives" point in different directions, one leading toward interventions to change society, the other toward interventions to assist the individual in getting along in the existing society. In child welfare, both are at work, in the simultaneous efforts to build a stronger community to support families and to enable families to cope with current circumstances.

The social work profession has its roots in the struggle to change the community, the first "grand narrative" that Kreuger identifies, so that individuals will have more social and economic opportunity. The settlement houses, which provided education for immigrants and were a center of endless reform efforts; the social survey movement, which documented the plight of the economically disadvantaged; the early work of the Children's Bureau for the health and economic security of women and children—all were focused on changing conditions for the vulnerable. This advocacy and reform impetus laid a strong value base for the profession. The second "grand narrative" identified by Kreuger has provided a different set of values that undergird direct practice. One is the belief that change is possible and that the individual is capable of lifelong growth. Another is the respect for the uniqueness of the individual and the individual's capacity to make judgments and guide his or her own life. Values of freedom and the right to privacy are buried in these constructs.

Clearly, there are values that tie these positions together or the profession would have splintered. One is the idea that everyone should have access to opportunity and the ability to take advantage of that opportunity: one marker of successful social work intervention is the maximizing of individual choices. Another is the idea that individuals are capable of making changes, in themselves or in their communities. A third is the enhancing of individual responsibility to the community.

Specht and Courtney suggest that the true mission of social work is that of building communities and working with individuals to accept responsibility as community members. Along with many in the profession, they advocate for a return to this focus. Meezan, in his address on the future of children's services quoted earlier, makes the same point, noting also that community building is far easier to espouse than to accomplish. Ortega and Reed (2013) outline the complexities of community building across cultures. These ideas point toward the new direction in social work—or perhaps it is a return to an older mission.

Child Welfare

Child welfare also has a complex history. Its focus has shifted as communities identify new problems, but the struggle to find ways

to enrich the lives of vulnerable children has always remained paramount. Beginning as a "child saving" movement, early child welfare practitioners (whether town selectmen or the leaders of movements such as Charles Loring Brace's shipments of children to the farming families of the West) intended to educate children in the ways of religion and productive work, thus saving them from idleness and ruin. The late nineteenth and early twentieth centuries saw the rise of a child rescue movement, as private child protective societies were formed to protect children from parental cruelty—an extension of the societies for the prevention of cruelty to animals. From these societies came the idea that children had rights and fuller discussion of the rights of parents and the rights of children. In the early 1900s, ideas of "scientific charity" and "social work" were introduced, bringing to the child rescue movement the idea that support of the child's own home might be a possibility and that, if a child was removed, reunification of the family should be a goal.

Through all of these child welfare "movements," the focus was on the individual child and family. At the same time, during the Progressive era of the late nineteenth and early twentieth centuries, early social work introduced the idea in child welfare practice of changing the community conditions in which children grew. This era, in which social workers were prominent, brought an expansion of the protections to children, such as the child labor movement and the establishment of the juvenile courts, and also an increased focus on programs that would benefit families, such as maternal and child health, and on income maintenance. This dual emphasis on child protection and family enhancement endures today.

Policy and Practice in Social Work and Child Welfare

The Progressive era was probably the time when the early social workers and the early child welfare workers were most closely aligned. Although part of the social work profession later wandered off into therapeutic halls and child welfare was partly de-professionalized, they have remained linked. The basic skills of work with individuals and families, as explained in social casework texts, are grounded in the practical realities of everyday life. These fundamental skills have been very useful, helping individuals and families learn to solve problems, use strengths, and maximize the opportunities available to them in their communities. As social workers moved into positions in child welfare, they brought with them their skill in working with individual families, increasing the possibility of rebuilding families rather than removing children from them. However, neither social work nor child welfare has emphasized the dimension of enabling individuals to contribute to their communities.

The strongest links between social work and child welfare are the shared value system and a shared set of skills. Social workers struggle with the investigatory nature of protective work and with the concomitant intervention in family life. But when these functions are successfully brought together by a skilled social worker, using the basic principles of social work practice, the resulting opening of opportunities and choices for families and children can be impressive.

A Note About Case Examples

Throughout the book, case examples are used to illustrate various facets of child welfare practice. These examples are almost all drawn from research completed at the Graduate School of Social Work at Portland State University in Portland, Oregon, under the auspices of the Child Welfare Partnership and the Regional Research Institute for Human Services. Child welfare practice with involuntary clients was examined in this research through interviews with families, caseworkers, foster parents, and community partners. Case examples use the words of the participants, drawn from transcripts of interviews, to illustrate concepts developed in the text.

Briefly, the project monitored the implementation of a statewide practice reform in Oregon's State Office for Services to Children and Families. The practice model focuses on (1) initial building of a relationship between caseworker and family through developing agreement about the needs of the children, (2) a planning process that builds on family strengths and the family's perspective in identifying needs and planning services, (3) services identified or crafted to meet specific needs, and (4) flexible funding to ensure that services can be found or created as necessary to meet identified needs. The issues in the implementation of this model, particularly in protective services, are many and fascinating. For those who may want to explore the model and its implementation in greater depth, the research is reported in a series of reports, which are listed in the references (Shireman et al. 1998, 1999, 2000, 2001). The final report (Shireman et al. 2001) summarizes the project and is available at www.rri.pdx.edu/Project/744.

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1

The Context of Child Welfare Services

Do Lawd, come down here and walk amongst yo people
And tak 'em by the hand and telt 'em
That yo ain't hex wid 'em
And do Lawd come yoself,
Don't send yo son,
Cause dis ain't no place for chillen.

—Prayer composed by slaves, 1866

Today there is increasing recognition that the solutions to social problems lie within their broad societal context. Thus, the task of promoting the welfare of the child demands a focus broader than the child or even the child and family. The community provides the cultural and value framework within which families function and may or may not provide sufficient supports to enable the family to function adequately. Socioeconomic, cultural, and political forces combine to provide a complex and ever-changing mix of demand, opportunity, barriers, and resources. Policy affecting the lives of children and families is formed as a result of this dynamic interaction.

The scope of the child welfare services available to children is dependent on the community's definition of the needs of children. The manner in which the community identifies these needs will depend to a very large degree on how the forces of the larger world shape the community, as well as upon the culture and resources of the particular community. The family difficulties that are recognized as social problems change over time. This chapter traces some of those changes and outlines the context within which child welfare services work.

The community sets the standards of care that it expects for its children, and the community sanctions and funds the child welfare workers who try to ensure that children have that care. But the social worker does not only carry out the wishes of the community. The social worker who in the course of daily work discovers conditions that harm children has a responsibility to advocate for change. The worker must know the community intimately, for more and more, child welfare workers are called on to find and use community resources for the families they serve and to help develop community resources that those families need. Thus, an important backdrop for a study of current child welfare policy is an overview of how community forces shape the lives of families and of how changing community definitions of social problems affect the commitment of resources.

In looking back at the history of children in the United States, the reader will discover the role of social work in alerting the public to the needs of children and mobilizing public opinion to intervene and make life better for children. This introductory chapter discusses problems that have been solved through the advocacy of those working with families and problems that continue to call for remedial attention: poverty (and the related history of child labor), education that is often inadequate, the changing family, substance abuse, violence, and the maltreatment of children. Racism underlies and compounds all of these issues. The role assigned to mothers as caretakers of children demands constant examination, as does the absence of fathers. In later chapters,

we will examine the major ways in which social work and the allied professions have intervened in attempts to solve these social problems—never fully reaching goals, but succeeding in producing meaningful changes.

Changing Community Expectations

Community standards and customs change over time. Progress in bettering the lives of all children is evident if one begins a review of changing community standards with a look back to the condition of children in the eighteenth and nineteenth centuries. As the nineteenth century became the twentieth, child labor laws and compulsory education laws were passed. The first half of the twentieth century saw enormous strides in the guarantee of a basic income for families, so children could be cared for at home—and then the end of the century saw the erosion of this promise. The second half of that century saw increasing concern with child maltreatment, as physical abuse, sexual abuse, and family violence were successively identified as major threats to children. As this problem became evident, the focus of child welfare narrowed to child protection—only in very recent years has this focus expanded.

The initial response to the discovery of child maltreatment was to rescue the children from the offending families, ensuring safety. Safety thus became and has remained a primary goal of child welfare services. As workers gained experience with each of the above types of maltreatment, they learned that it was often possible to keep children safe within their own homes, and they learned that out-of-home care too often led to multiple separations and serious developmental problems. A second goal developed: ensuring that every child had a permanent home—the original home or an adoptive home. And in recent years, as ongoing research has illuminated the needs of children in out-of-home care and the difficulties of families in the community, the goal of tending to the overall well-being of each child has developed. This is currently expressed in attempting to keep children with their families, either parents or extended families, and providing family support services. Responsibility for meeting the developmental needs of each child under care in the child welfare system, including the provision of mental health, medical, and educational services to children, is necessary to ensure well-being.

The programs and services integral to child welfare have shifted over time. The reformers of the Progressive era (late nineteenth and early twentieth centuries) argued for a greater federal and state government role in the resolution of social problems. These years saw an increasing development of government programs and movement toward federal provision of resources and standard setting. Such programs continued to expand through the years of the New Deal (the 1930s) and the War on Poverty (the 1960s), then began to contract and grow ever more constricted in the last three decades of the century.

Many social problems remain: too many children are poor; too many children do not have health care; too many children lack affordable, high-quality day care; too many children with special needs lack the services that would help. Families who are at risk need preventive services, and families in which children have been abused or neglected need a wider range of better-funded and more imaginative remedial services. But progress has been made, and social workers have often led the way.

The following sections review a few of the major social problems that affect our communities today, particularly those in which social workers, or their predecessor social welfare workers, have displayed a particular interest. We begin with the history of change regarding two social problems—child labor and juvenile delinquency—to illustrate the impact that a determined group of child advocates, in this case social welfare workers, can have. It is an optimistic start to a look at a multitude of serious problems that today demand action.

A Legacy of Advocacy and Change: Social Work at the Start of the Twentieth Century

From colonial times, it has been considered important that children learn the habits of work as preparation for adult life. Education was also valued as a necessity for governance in a democratic society. The difficulties of children in a justice system designed for adults were also recognized. These stories serve as examples of the investment of early social workers in the welfare of children.

Child Labor Closely linked to poverty, child labor was recognized in the late nineteenth century as a social problem, and the early social workers were instrumental in changing the conditions faced by children in the factories.

During the nineteenth century, there was a growing recognition that factory employment kept children from becoming educated and that a democracy would be ill served by a population that could not read or write. Poor families depended on the wages of all family members. Manufacturers were eager to employ children because they could be hired for low wages and because their dexterity was an advantage. Thus, women and children formed a large proportion of the industrial workforce. Testimony before the Pennsylvania Senate in the 1830s described the conditions of employment:

> The hours vary in different establishments; in some I have worked fourteen and a half hours. . . . It is most common to work as long as they can see; in the winter they work until eight o'clock, receiving an hour and a half for meals. . . . The children are employed at spinning or carding. . . . I have known children of nine years of age to be employed at spinning—at carding, as young as ten years. Punishment, by whipping, is frequent; they are sometimes sent home and docked for not attending punctually. . . . The children are tired when they leave the factory. I have known them to sleep in corners and other places, before leaving the factory, from fatigue. The younger children are generally very much fatigued. . . . The wages of children are not regulated by the number of hours they labor; I have known some to get no more than fifty cents per week; I have known some to get as much as $1.25. (*Journal of the Senate of the Commonwealth of Pennsylvania*, session of 1837–38, testimony of William Shaw, as reported in Abbott 1938a:280–81)

Social reformers—among them Jane Addams, Florence Kelley, Grace and Edith Abbott, Sophonisba Breckinridge—were active in support of the child labor and compulsory education laws. Labor unions also supported these laws because the employment of children at low wages undercut their demands for better wages and working conditions. Of course, there was great opposition to these laws, from employers and, sadly, from poor parents who "thought the sacrifice of their children necessary" and saw themselves as in great need of, and having a right to, their children's earnings (Abbott 1938a:263).

Early child labor laws passed by states protected only children in factories; those protecting children in less regulated industries, such as street peddlers, or children working in home industries followed more slowly. (The protection of children who work in the fields, particularly the children of migrant workers, has still not been accomplished.) The first child labor law in 1916 was followed by a series of attempts to enact federal legislation to protect children. All were declared unconstitutional, deemed to overreach the regulatory powers granted to the federal government in the Constitution. An attempt to pass a constitutional amendment in the 1920s was unsuccessful. During this time, many states passed laws regulating child labor, but not until 1938 with the passage of the Fair Labor Standards Act did federal legislation succeed in restricting child labor (Costin, Bell, and Downs 1991).

Compulsory Public Education Compulsory public education and child labor laws were linked; it was thought that children needed

education and feared that children not in factories might be "idle" if not required to go to school. The first compulsory education law in Illinois (1889)

> made unlawful for any person, firm, or corporation to employ or hire any child under thirteen years of age without a certificate, but the board of education was given authority to excuse any such child from school and to authorize his employment, provided his labor was needed for the support of any aged or infirm relative and provided the child had attended school at least eight weeks in the current year. The system of allowing children to work if their relatives seemed to be in need meant, of course, that the children most in need of the protection of child labor and compulsory education laws would be entirely excluded from their benefits. (Abbott and Breckinridge 1917:69)

As further compulsory education laws were passed, the shortage of schools and teachers became evident. A report to the Chicago school board in 1896 complained that

> until there are schools for the children, and a compulsory education law that is enforced, the factory inspectors cannot keep all the children under fourteen years out of factories and workshops. . . . In Chicago, the City Council has taken a distinctly retrograde step in reducing the school appropriations by $2,000,000 for 1896–97, thus checking the building of school houses, and depriving thousands of working-class children of the opportunity for school life which primary schools are supposed to extend to all alike. (Report of Florence Kelley to the Chicago School Board, 1896, as reported in Abbott and Breckinridge 1917:81–82)

The development of a school system that could accommodate and educate the many children now free to attend school was a massive undertaking, one that is still in progress.

By the end of the 1930s, then, there were laws protecting children from being exploited in difficult working conditions and laws giving children the opportunity to be educated in public schools. Community support for these laws was widespread. The concept that the child needed to be trained to be a useful citizen had not been abandoned, but industrialization had given a different focus to that training; school became the route to productive citizenship.

Although child labor and education laws greatly changed the condition of children, the problems they addressed are not completely in the past. There is continuing concern about children who work and whose schooling is disrupted; this is particularly of concern with migrant families who follow crops to work in the fields. There is also widespread concern about young people who do not complete the schooling necessary for productive adult lives. In 2008, 81 percent of white students and 91 percent of Asian students received a high school diploma or equivalency certificate, as did only 64.2 percent of Native American students, 63.5 percent of Hispanic students, and only 61.5 percent of African American students (Children's Defense Fund 2011). This disparity is linked to poverty and to racism. Because schools are locally funded, schools in poor communities have few resources; many African American and Hispanic children live in the poorest of our communities. Child advocates still have work to do to secure equal opportunity through universal education.

The Juvenile Court During the same era that laws were being passed regarding child labor and universal education, reform of the way the justice system handled children took place. For the greater part of our history, those who broke the law were seen as rational human beings, capable of making decisions and controlling their behavior. They were to be held accountable for their actions. Only children under the age of 7 years were presumed incapable of criminal intent. Those 7 years of age or older could be tried in criminal court and, if found guilty, could be sentenced to prison or even to death.[1]

Beginning with the nineteenth century, however, a new philosophy began to emerge based on a belief that human behavior, whether it violated the law or not, was the natural consequence of antecedent causes, many external to the individual. These causes could be determined and understood. Thus, the "era of the rehabilitative ideal" emerged and, with it, the concept of the state's use of services better to promote societal welfare in general and child and youth welfare in particular. The most notable step toward the operationalization of this new philosophy took place in Chicago, Illinois, with the founding in 1899 of the Cook County Juvenile Court:

> Mrs. Lucy L. Flower, Julia C. Lathrop, and Jane Addams were the moving spirits in formulating the new and basically different conception of the treatment of juvenile delinquents which it represented. . . . The problem was to find out how to make a fundamental change in criminal law and criminal procedure which would be upheld by the courts as constitutional. In cooperation with a committee of the Chicago Bar Association, a bill was finally worked out and agreed upon by the interested groups. . . . With the help of leading Chicago lawyers a plan was developed for giving the Illinois courts of equity jurisdiction over child offenders. The first juvenile court law passed in 1899 was called "An Act to Regulate the Treatment and Control of Dependent, Neglected, and Delinquent Children." (Abbott 1938b:330–31)

This was the first statutorily created juvenile court in the United States and possibly in the world. It came about as a result of the joint efforts of the Chicago Bar Association and of major social work pioneers and educators of the time, notably Julia Lathrop at Hull House. By 1925, all but two states had juvenile courts and, most usually, probation services.[2] During this era, in an attempt to remove children from adult jails, institutions specifically for delinquent boys and girls were established.

The juvenile court employed an earlier British doctrine of *parens patriae*, the state as the ultimate parent. Because children did not have full legal capacity, the state had the responsibility to intervene for the welfare of the child when the parents failed in or were incapable of carrying out their responsibilities. Thus, the court also had jurisdiction over charges of parental neglect or abuse of children and over status offenses (actions constituting law violations when committed by children, though not when committed by adults, such as running away, truancy, failure to obey parents, and a myriad of other "nuisance offenses") thought to be possible precursors of serious difficulties.

> In the early days of the juvenile court movement it was discovered that the judge alone was unequal to the new tasks which the juvenile court laws laid upon him. Applying a sentence fixed by the law after a determination of guilt was a simple matter compared to treatment with a view to cure. As this was appreciated, a series of auxiliary services and clinics were set up, usually however only in metropolitan centers, to advise and assist the court. (Abbott 1938b:334)

The juvenile court was obviously a child welfare agency as well as one charged with carrying out for children, when necessary, the punishment, incapacitation, and societal protection functions of the criminal law. This was a true revolution in delinquency philosophy and practice, and it was widely hailed as such.

Later Supreme Court decisions modified the discretionary powers of the juvenile court judge. In 1967 in the landmark cases *In re Gault* and *Kent v. United States*, the Supreme Court established the right of juveniles to due process protection when their freedom was threatened by the power of the state[3]:

> The evolution of children's rights in America is divided into four periods: pre-nineteenth century, 1800–1900, 1900–1967, and 1967 forward. Prior to the nineteenth century children were considered their parents property to do with as they saw fit. In the nineteenth century with industrialization and

> urbanization leading to neglect, abandonment, and exploitation of children, benevolent laws and institutions were established to offer protection to children. In the early years of the twentieth century, juvenile courts and the attitude of benevolent oversight of orphaned, abandoned, neglected, abused, and delinquent children predominated. In re Gault and Kent v. United States, decided by the U.S. Supreme Court in 1966 [decisions giving juveniles the right to due process protections in juvenile court], marked the beginning of the children's legal rights era. (Downs et al. 2000:47)

These decisions had impact on the procedures of the juvenile court, introducing the adversarial framework of the adult court system. Still, however, the focus of the juvenile court was on rehabilitation of the offender rather than punishment.

However, the past three decades have seen a counterrevolution. The juvenile court and justice system came under bitter attack as instruments for supposed "coddling" and protecting of young criminals. Public perception has been of a supposed "juvenile crime wave" demanding an increasingly "get tough" approach. This approach emphasizes higher rates of arrest, use of more secure and punitive institutions, and longer sentences. If after such tactics are employed, delinquency rates fail to decline, the public perception tends to be that we must get tougher still, whether or not there is any research substantiating the presumed capacity to solve the "juvenile crime problem" through "get tough" measures.

Recently, this punitive stance has been increasingly questioned. Juvenile crime rates are not increasing. There is great concern about the disproportionate number of youth of color that are incarcerated. Increasingly, there is recognition that confinement does little to assist a youth in overcoming barriers to success and that programs that help youth regain their places in the community may be more appropriate. These contrasting points of view demand careful, thoughtful scrutiny of the extent and nature of juvenile delinquency and of the efforts being made to cope with it. The philosophy of the founders of the juvenile court remains an active force in this debate.

The Changing Family

The structure of the American family has been changing over the past hundred years; each significant change was probably viewed as a social problem by the community, and certain segments of it agitated to return to earlier ways. At the beginning of the nineteenth century, men held a dominant position in families as the sole provider of income, retaining almost all control of property and of decision making. If the parents separated, which happened rarely, the father retained custody of the children. Change has been gradual, aided by the increasing acquisition by women of rights and economic power and by the judicial recognition of the bond between mothers and children and of mothers' role as primary caretakers of children.

Women in the Workforce Between 1970 and 2009, the participation of women in the labor force increased greatly; the increase is particularly notable among women with children. From March 1975 to March 2009, labor force participation of mothers with children less than 18 years of age rose from 47.4 percent to 71.6 percent. In general, women with older children (over 6 years of age) are more likely to work outside the home. Unmarried mothers are also more likely to be employed: 75.8 percent are employed, compared with 69.8 percent of married mothers. Earnings have also increased, with women working full-time earning 62 percent of what men did in 1979 and 80 percent in 2009 (U.S. Bureau of Labor Statistics 2010).

The entry of women into the workforce has created less change in either the world of employment or in the home than might have been hoped. Although the proportion of women working full-time outside the home has increased greatly, and though many men are

taking up household responsibilities, women still carry the major responsibility for the care of the home and the raising of the children. Though "family friendly" policies have invaded some workplaces, many jobs, particularly those that are low paying, are tied to specific hours, have little or no flexibility, and carry few or no health benefits. Child care has become vital, and working parents often look desperately for high-quality and affordable child care.

New Forms of Families The last half of the twentieth century brought a dramatic change in family composition. The divorce rate is high and stable—about half of all marriages end in divorce. Men average three years after a divorce before remarriage and women average six years; thus blended families are created. Families form without formal marriage; in 2008 about 40 percent of births in the United States were outside marriage (Federal Interagency Forum on Child and Family Statistics 2010). Single parents raise children. Gay men and lesbian women form families and raise children. The traditional two-parent family raising its biological children is no longer the dominant model.

There is now greater acceptance of the single woman bearing and raising a child than there has been in the past. About 20 percent of all children and 50 percent of African American children live in a single-parent household headed by their mother (Children's Defense Fund 2011). Though most single-parent households are headed by women, fathers also raise children; in 2010, 3.4 percent were living with their father (Children's Defense Fund 2011). The greatest problem for single parents has been poverty, for there is only one wage, and a woman's wage is generally less than a man's. The fact that children living with only one parent are almost five times as likely to be poor as children living with both parents cannot help but be of concern (Children's Defense Fund 2011). Poverty, of course, complicates other aspects of the single parent's life—finding affordable day care, finding time to take children to doctors and dentists and to go to school appointments, finding a way to have some respite from the constancy of parenting.

The role of fathers is beginning to receive more attention. Child support has always been the responsibility of absent fathers; recent legislation makes it more difficult to evade payment. Services designed to help fathers become a part of the lives of their families are beginning to develop, and federal funds are for the first time directed at helping young men gain skills for productive employment, in the hope that they can then support their families.[4] The recession that began around 2008 created large numbers of unemployed; in families where the wife had work and the father did not, it became increasingly common for the father to become the chief caretaker of children. By 2010, 32 percent of fathers regularly cared for children; among fathers with preschool children, 20 percent were the primary caregivers (U.S. Census 2011a). The contrast with the patriarchal family roles of the previous century is notable.

Women's Roles Society still defines the "proper" roles for women as marrying, having children, and caring for husband, children, and household. This framework is important in child welfare, for built into the child welfare system is the expectation that mothers will care for and protect their children. When this does not happen, mothers are blamed and expected to be the catalyst for family change.

Recent welfare reforms (described at the end of this chapter) make it clear that women are also expected to earn enough to support their families. Maluccio, Pine, and Tracy (2002:21) point out that

> [t]his view of women as responsible for care giving does not extend to single mothers receiving welfare assistance. When their term of eligibility for assistance is expiring, these women are virtually forced to seek employment, sometimes without much support for securing appropriate child care. . . . As a result these women may be viewed

as doing neither wage-earning or parenting well enough.

Swift (1995) carries these ideas further, suggesting that the structures of society make it extremely difficult for poor women to fulfill their expected roles, and suggesting that with their unrealistic expectations, society and the child welfare system have "manufactured" bad mothers.

Because child welfare work focuses so intensely on mothers, it is imperative that we deliberately and frequently step back and view our world through a feminist lens. Though the needs of children may impel action, and though family change may be the children's greatest need, we must always be conscious of the responsibility to advocate for change in the societal conditions that contribute to impoverished or aversive family life for children. Child welfare workers need to be aware of the burden that poor mothers carry as they raise their children.

Community Problems Affecting Children and Families

There is no attempt in this section to create an exhaustive discussion of the difficulties our communities face. Rather, only a few community problems that create stress for children and families have been identified, and these are described quite briefly. The intent is to set the stage for thinking about the interrelationship of the family and community, and to stimulate the reader to identify even more community issues that impact children and families. To create optimum conditions for child development, communities should provide supports for parents. To the extent that communities fail to do so, or even hinder parenting, they impact children's lives.

The Impact of Adverse Childhood Experiences

Those working with children have long realized that difficult early experiences disrupted development and created long-term problems for children; this "practice wisdom" has been affirmed by recent research. First, new brain-imaging techniques enabled us to see the neurologic consequences of stress, and the capacity for recovery, in very young children. It became apparent that central nervous system organization, and consequently behavior, was a function of experience (Weiss and Wagner 1998). Then the long-term effect of trauma and stress for children was established by the findings of the Adverse Childhood Experiences Study (ACES; Felitti et al. 1998). The impact of this work has focused attention on the importance of prevention.

ACES is a large and relatively simple study. Between 1995 and 1997, physicians at Kaiser Permanente gathered information about the childhood experiences of 13,474 patients who had come for routine physical examination. Questions were asked about physical, psychological, or sexual abuse; violence against the mother; living with household members who were substance abusers, mentally ill or suicidal, or ever imprisoned. Almost two thirds of these patients reported experiences of maltreatment and family dysfunction as children. An ACE score was developed—a simple count of the number of these experiences. The research team found "a strong, graded relationship between the breadth of exposure to abuse or household dysfunction during childhood and multiple risk factors for several of the leading causes of death in adults" (Felitti et al. 1998:245). Research continues with varied populations and with investigation of varied combinations of adverse childhood events, with the basic finding consistently replicated.

Racism

It might be said that racism is the hidden social problem of our time—not hidden from those who experience it, but hidden from the mainstream community that must provide the resources to combat it. It affects children in many ways. Most notably, children of color are economically disadvantaged, with a

disproportionate number living in poverty (see the final section of this chapter). The statistics that show the extent to which children of color live in poverty speak of deteriorated communities, inadequate schools, and the despair of parents. These are children who are being denied opportunity in an affluent society, and parents who are raising children without community support. As the reader continues in this book, he or she will find disproportionate representation of children of color over and over again in the various child welfare services. Of related concern are the subtle and seldom recognized biases that arise from the largely white and middle-class culture of child welfare agencies. These issues are further explored in the final section of chapter 3.

Homelessness

Homelessness is a problem for an increasing number of families with young children. A major cause is poverty, leading to inability to afford available housing; other causes of homelessness may be an unhealthy physical environment, drug or alcohol abuse in the home, or family violence (National Center for Homeless Education 2012). Although economic hard times have always led to some displacement and migration of children and families, the proliferation of working families simply unable to afford housing seems to be a fairly recent urban phenomenon. It is estimated that about a quarter of the homeless are families with children; a 2007 survey by the U.S. Conference of Mayors found that families with children were 23 percent of those in homeless shelters (U.S. Conference of Mayors 2008). The number of homeless children has increased rapidly with the economic downturn that began in 2008; in 2009 there were 950,762 school-age children and 33,433 preschool children without homes (Children's Defense Fund 2011). This is an increase of more than 40 percent in one year.

Unfortunately, the supply of affordable housing for those with very low incomes is diminishing. And current federal policy initiatives that grant greater discretionary power to local housing authorities regarding the use of federal housing subsidies may worsen the situation if local authorities decide to lower subsidies or qualify income levels.

Lack of adequate shelter is particularly hard on children. Poor housing with inadequate heating and/or deteriorated plumbing offers risks to health; old housing presents the risk of lead poisoning from older lead-based paint; structural deterioration may put young children at risk of accidental injury. Poor families often move from place to place in an attempt to secure better housing; these moves disrupt the sense of predictability and stability that children need. When families cannot afford housing, they live where they can find shelter: in a car (4.8 percent), in a shelter (28.1 percent), in a motel (6.8 percent), or "doubled up" with friends or relatives (66.3 percent; Children's Defense Fund 2011).

As the instability of homelessness undermines the feelings of safety that are important to development, continuity of school experience assumes importance. The McKinney-Vento Homeless Assistance Act of 2001, a federal statute that is part of the Leave No Child Behind Act, mandates that children must have opportunity to continue in the school they were in before they lost their housing and have transportation to that school provided or be immediately enrolled, without documentation such as proof of residency or former school records, in the school where they are currently residing. They also cannot be separated from the regular school program. Thus, schools make considerable effort to provide continuity of education.

Of course, this ultimate crisis of having no home creates enormous disruption and stress. It is among the stresses that can lead to subsequent mental and physical health problems.

Hunger

In a country as prosperous as the United States, it is difficult to imagine children not having enough food. However, one in ten children lives

in a household with limited access to adequate food (Children's Defense Fund 2011). For most of these households, low income is what limits their access; more than a third of families with incomes below the poverty threshold were food insecure. Poverty is associated with race; children of color are more likely to face food insecurity than are white children. Families with the highest prevalence of household food insecurity are African Americans (22 percent), Latinos (22.3 percent), those with children under 6 years of age (17.7 percent), and single-mother households (30.4 percent; Cook and Jeng 2009). Two federal programs are focused on alleviating childhood hunger, the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) and the Supplemental Nutrition Assistance Program (SNAP, popularly known as food stamps). Apparently these are not sufficient.

Inadequate nutrition has serious consequences for child development, particularly among young children. Their health is compromised, and they suffer growth impairment. Perhaps most seriously, inadequate nutrition during critical developmental periods harms the emotional and cognitive development of children, actually changing the fundamental neurologic architecture of the brain. Children who have had inadequate nutrition or currently do not have enough to eat do less well in school. Concentration is a problem. They have more social and behavioral problems because they lack the energy for complex social interactions. They do not adapt as well to stress (Cook and Jeng 2009). Hunger thus has long-term consequences, in addition to immediate discomfort. There is no reason that children should be hungry in a country as rich in food resources as the United States.

Substance Abuse

Substance abuse is a relatively recent addition to the list of social problems recognized by the community. For years, alcohol has created tremendous difficulties for families and children, but alcoholism has been considered a personal or family problem, not a target for community intervention. The use of illegal drugs, and the quest to obtain them, has destroyed families and created even greater chaos. The extent of drug usage, and its linkage with violence and illegal activity, has clearly made it a community problem. Substance abuse in the home is associated with long-term consequences for children, as demonstrated by ACES.

Parents abuse substances at a lower rate than the general population; still, 11.9 percent of children in the United States live with at least one parent who is in need of treatment for substance abuse. Of these, 7.3 million live with a parent who is alcoholic, 2.1 million live with a parent who is dependent on or abuses an illicit drug, and 8.3 million live with a parent who abuses both alcohol and illicit drugs (Substance Abuse and Mental Health Services Administration, Office of Applied Studies 2009).

When these children come in contact with the child welfare system, the referral will usually be for abuse or neglect. Children of substance-abusing parents are more likely to be placed in foster care, and to remain there longer, than children whose parents have other problems (U.S. Department of Health and Human Services 1999; Wulczyn 2009).[5] If placed in foster care, they are more likely to be adopted rather than return to their parents (Wulczyn 2009).

The growth during the 1980s in the numbers of young children in foster care was associated with the appearance of crack cocaine in the major cities, though causality could not be demonstrated. From 1995 to 2005, there was an increase in the manufacture and use of methamphetamine and there is some evidence that this may have led to increased numbers of foster care placements (Cunningham and Finlay 2013), partly because of the dangerous home conditions created by the manufacture of the drug. It is estimated that for about two thirds of the children in foster care, parental substance abuse is a problem (U.S. Department of Health and Human Services 1999). It is a critical issue for

child welfare policy and will reappear frequently in subsequent chapters of this book.

Violence in the Community

In 2008, a national survey of the incidence and prevalence of children's exposure to violence produced astounding data. The survey measured the past year and lifetime exposure of children (under 17 years of age) to violence across several major categories: conventional crime, child maltreatment, victimization by peers and siblings, sexual victimization, witnessing and indirect victimization including exposure to community violence and family violence, school violence and threats, and Internet victimization (Finkelhor et al. 2010). More than 60 percent of the children surveyed reported exposure to actual violence—either direct involvement in the violence or witnessing violence during the past year. Lifetime exposure was one half to one third higher than exposure during the past year and included exposure to multiple types of violence. Maltreatment and domestic violence have long been recognized as areas of concern for child welfare; these survey results suggest that community violence is also a major issue.

Some communities are more violent than others. Low-income and minority youth are much more likely to have witnessed serious violence in the community; one study found that only 1 percent of upper-middle-class youth had witnessed a murder and 9 percent had witnessed a stabbing, whereas 43 percent of low-income African American school-aged children had witnessed a murder and 56 percent had witnessed a stabbing (Kracke and Hahn 2008). Gun violence is endemic. In 2007, 3,042 children died every day as a result of homicide, suicide, or accidentals shootings. Almost six times as many suffered nonfatal gun injuries. African American males aged 15–19 are more than five times as likely as white males to be killed by a firearm (Children's Defense Fund 2011).

Bullying has received much attention and takes its place with more serious violence in affecting the future of children. More than 20 percent of children surveyed report having been physically bullied; 30 percent report having been teased or emotionally bullied. Bullying was most common during middle childhood. Youth age 10 and older were asked about Internet harassment, and 8 percent reported having experienced it (Finkelhor et al. 2010).

We are continually learning more about the impact of violence on children. We know that exposure to violence can be a traumatic event. We are learning that, while some children recover spontaneously from the trauma of witnessing violence, some do not and continue to have posttraumatic symptoms. We are learning that chronic anxiety and stress during early childhood affect the physical development of the brain. Some children exhibit resilience, but we do not fully understand what creates and supports this resilience. We do know that there is a community responsibility to create a safe place for children—at home, in school, in the neighborhood.

Abuse and Neglect of Children

As discussed in the introduction, the protection of children in recent years, has become a focus of child welfare services. The expansion of these services since the turn of the century to encompass a broader spectrum of concerns about children has not negated the importance of protection, but has stemmed from increasing interest in prevention. Of all the services of child welfare, the work with families that abuse and neglect their children is the issue about which there is most community concern, the most community debate about appropriate policy, and the most criticism of existing child welfare services. Services in place to protect children also consume most of the resources of child welfare agencies.

Pecora et al. (2009) remind us that child maltreatment, though usually thought of in the context of family, occurs also at the community, societal, and institutional levels. At the community level, it occurs when the problems

outlined earlier in this chapter result in inadequate support for families as they care for children: safe housing, adequate educational and employment opportunities, equal opportunities, a violence-free environment. At the societal level it is reflected in the cultural condoning of violence toward children and women. At the institutional level, maltreatment occurs when schools, legal authorities, or institutions designed to care for children and families fail to provide adequate treatment of all children. Most child welfare intervention is focused at the family level, though in recent years community intervention has received increasing attention in the social work literature (for example, Adams and Nelson 1995; Meezan 1999; Daro and Dodge 2009). Certainly all four levels should be considered.

Defining Maltreatment

Community definitions of maltreatment have changed over time, as the standards of the community have changed. Generally, these definitions have reflected the increasing recognition of childhood as a life stage during which there are particular developmental needs and of children as persons with rights. This view has gradually replaced earlier perspectives in which children were seen as property under the absolute control of parents.

Neglect and physical abuse were first recognized, followed by community concern about sexual abuse and, most recently, concern about the exposure of children to family violence. As each of these types of abuse was recognized as a social problem, a pattern of service delivery was repeated. At first, children were "rescued" and removed from their homes. Gradually knowledge was gained, in each of these types of maltreatment, about ways to keep children safe in their own homes, and more sophisticated work with families began.

Neglect Neglect has always been present. It is the most common form of maltreatment, as shown in figure 1.1. It can be defined as failure to meet a child's needs, resulting in harm to the child, either immediately or in the future. Often discussed is whether there is a universal definition of neglect or whether it varies according to cultural tradition and community setting. Another frequently debated issue is whether harm to the child should be evident or whether long-term threats to child development also constitute neglect. Neglect also should be distinguished from failure to meet a child's physical needs due to poverty.

Neglect can be physical, emotional, medical, or educational. In its most severe form it is life threatening. Neglect is almost always a chronic condition. In all instances, the developmental consequences of neglect are serious.

Physical neglect occurs when parents do not provide for the basic needs of a child. Most common are inadequate food, clothing inappropriate for the weather, lack of a home, or a home in which conditions are unsafe—either because of physical hazards or because extremely poor housekeeping has resulted in health hazards. Failure to provide adequate supervision, including leaving children alone when they are young, is a common neglect complaint. Leaving children for long periods with a substitute caretaker, without planning with the caretaker about time of return, is another form of neglect. Abandonment is an extreme form of neglect.

Medical neglect occurs when parents fail to obtain needed medical care for a child. This can involve very complex legal and ethical issues if there is a religious reason that medical assistance is not sought. Some churches teach that reliance on prayer is the proper course of action in illness or forbid blood transfusions or other medical procedures. Federal guidelines state that exemptions to child neglect laws due to religious beliefs are the province of the states. The issue is a difficult one, for the state intervenes in family autonomy reluctantly, and the state cannot dictate its religion to a family.

A story from Oregon is typical of recent changes in several states (see box 1.1).

BOX 1.1

In Oregon in 1998, a child died at home after a fairly protracted illness that was diagnosed, after his death, as diabetes. His parents had been much concerned about the child's physical decline and about his discomfort, and had called in the pastor of their church to pray with them for the child's recovery. They had not sought medical help. Oregon law protected them from charges of neglect because of their adherence to an organized religion that prohibited medical intervention.

In the examination of this law and pressure for its repeal that followed this death, the Oregonian *newspaper examined the recent history of members of this church. It discovered an inordinate number of women who had died in childbirth and children who had died of diseases fairly easily handled with standard medical care. In this patriarchal sect, it was women and children who paid the price of the set of beliefs.*

Oregon's law was changed in 2011 in response to two high-profile deaths of children whose families were members of a church that believed in faith healing. Parents were no longer protected by reason of their religious beliefs. These are sad and difficult situations, and there was concern that the "good intentions" of the parents would protect them even if the new law did not. However, in November 2011 a mother and father received prison sentences after the death of a premature infant for whom no medical care had been sought.

Failure to thrive in infants or small children can be due to neglect, difficulties in feeding, or both; it is a condition diagnosed when a child fails to gain weight as growth charts predict, instead falling to the very lowest weight percentiles. It can be an organic condition, and it is vital that a proper diagnosis be made.

Educational neglect occurs when parents fail to comply with laws concerning school attendance. This is, of course, a fairly simplistic definition. Parents sometimes do not send their children to school because they do not approve of what is being taught; courts have upheld the right of parents to homeschool children. Other times, children are kept out of school to watch smaller children, to act as an interpreter for a non-English-speaking parent, to accomplish errands, or otherwise to help in the household. Some children do not go to school because parents simply cannot organize family life to get up and get started in the morning. And some children are truant because school is, in some aspect, intolerable for them. All of these, with the exception of home schooling, constitute educational neglect and each, clearly, has a very different remedy.

Physical Abuse Physical abuse is defined as deliberate physical injury to a child, regardless of the reasoning or intent of the abuser. It had always been of concern, and instances of extreme physical cruelty (combined with neglect) led to the founding of the first Societies for the Prevention of Cruelty to Children. Physical abuse includes severe physical punishment (including beating, scalding, poisoning, or close and aversive confinement of a child) or any nonaccidental action that creates the possibility of harm to the child. Though they vary among the states, statutes that define abuse emphasize that a child must have received serious injury or be at substantial risk of injury in order for the state to intervene in the family against the parents' wishes. The line between appropriate physical punishment and physical abuse is drawn differently in different communities and among different cultural groups, making the determination of abuse difficult in some circumstances.

Sexual Abuse Sexual abuse is subject to many definitions, and the prevalence rates vary with the definition. A common denominator of the definitions is the use of power to involve a child or immature adolescent in sexual activities for the gratification of the abuser. An important element is that, as children cannot comprehend the nature of sexual activities, they are unable to give informed consent. Sexual abuse includes fondling, penetrating a child's vagina or anus, engaging in indecent exposure, and exposing a

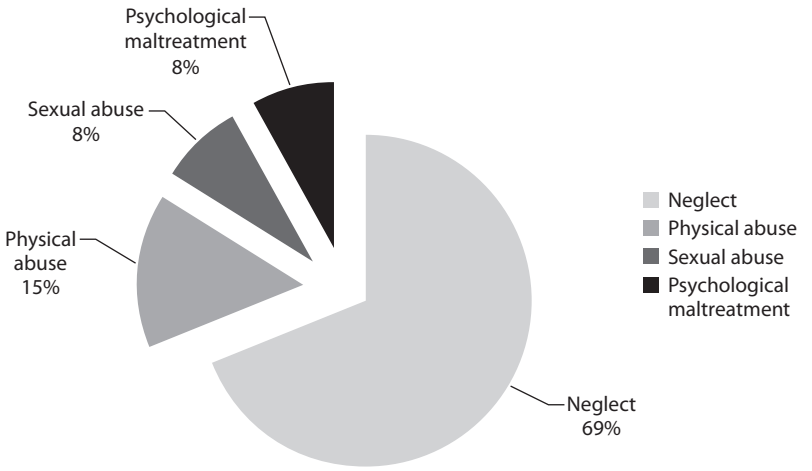

FIGURE 1.1. Percentage of children and types of maltreatment *Source:* NCANDS 2012 (U.S. Department of Health and Human Services 2012)

child to pornographic material. It also includes sexual exploitation—engaging a child or soliciting a child for the purposes of prostitution or using a child to film or photograph pornography (American Humane Association 2012b).

Emotional Maltreatment Emotional maltreatment, sometimes called psychological neglect or abuse, has received increasing prominence in recent years, though it remains difficult to define and difficult to substantiate in court. It includes actions such as constantly belittling the child and withholding praise and affection. Consistent failure to respond to a child's needs for nurturance and stimulation is emotional neglect; failure to thrive, a situation in which an infant or young child fails to gain weight, is considered a combination of emotional and physical neglect. Allowing a child to witness family violence can be defined as emotional neglect. Isolating a child, terrorizing a child, and actively rejecting a child are all examples of emotional neglect (American Humane Association 2012a). Emotional maltreatment (which often accompanies other abuse or neglect) has serious consequences and can be as crippling as the consequences of other forms of maltreatment.

The Extent of Child Abuse and Neglect

In 2011, estimates agree that about 4 million children were abused or neglected (60 percent of 6.3 million children who were the subjects of maltreatment reports, and the number harmed or endangered according to community estimates of incidence [Sedlak et al. 2010; U.S. Department of Health and Human Services 2012]). Until very recently, national data have indicated continually rising numbers of children who are abused or neglected. The number of reports rose from 416,000 in 1976 to almost 2 million in 1985 (Kadushin and Martin 1988) and to 3.3 million in 2011. After investigation, workers substantiated 60.9 percent of these referrals, concluding that abuse or neglect severe enough to meet statutory definitions has taken place. As shown in figure 1.1, approximately three quarters of these children were classified as victims of child neglect, while 17.6 percent suffered physical abuse and 9.1 percent sexual abuse (U.S. Department of Health and Human Services 2012). The Third National Incidence Study of Child Abuse and Neglect (NIS-3), which attempts to count actual maltreatment, not just reported maltreatment, also found a 67 percent increase in child maltreatment between 1986 and 1993 (Sedlak and Broadhurst 1996).

However, the Fourth National Incidence Study of Child Abuse and Neglect (NIS-4) discovered a 19 percent decrease between 1993 and 2005–2006 in the numbers of maltreated children. This change was due to the numbers of physically and sexually abused children declining sharply; the number of children who were neglected changed very little (Sedlak et al. 2010).

The source of these increased numbers of neglected children is unclear. Increasing numbers of families experiencing poverty, discussed at the end of this chapter, may contribute. We have noted the growing fragmentation of families and the many stresses facing young families. Traditional community supports—a network of relatives and neighbors, the church, the well-staffed school—may no longer be in place, particularly in transient and impoverished communities. It is possible that community standards for the care of children have risen (it is certain that they have, if one looks back toward the turn of the century). Whatever the reason, child welfare agencies are dealing with large numbers of reports and increased numbers of substantiated cases of maltreatment, particularly neglect.

The Consequences of Abuse and Neglect

For years we have known that child abuse and neglect had serious developmental consequences, beyond obvious bodily harm. Physically abused children tend to be aggressive and have diminished capacity for empathy. Children who have been neglected may evidence difficulty in forming attachments, and thus have difficulty mastering developmental tasks. The belittling and depreciation of emotional neglect rob a child of self-esteem, and indifference may be even more devastating, conveying the message that the child is not even worth attention (American Humane Association 2012a). Older children who have been abused or neglected are likely to perform poorly in school. They often experience emotional problems. As adolescents, substance abuse and juvenile delinquency become more common (English 1998).

Recent advances in brain imaging have begun to provide some explanation for these behaviors, showing that the chronic state of watchfulness and anxiety that a child experiences in an abusive family during critical developmental periods—particularly the first thirty-six months of a child's life—can alter the structure of the brain. This chronic stress can also occur when neglectful parents do not offer the nurturing support needed to help an infant or young child manage his distress. These basic changes may result in diminished capacity to self-regulate emotions and difficulties in trust and in forming attachments. This affects learning and the development of empathy (Karr-Morse and Wiley 1997; Shonkoff and Phillips 2000; Benedetti 2012).

Stress has been classified as "positive," "tolerable," and "toxic." Positive stress occurs when a child, supported by a caregiver, learns to manage everyday stressors, such as toys out of reach, a confrontation with a playmate, lunch being late. Tolerable stress is the reaction to more serious stressors, such as a loss or serious injury, but in a situation where the child is nurtured by a protective adult. Stress becomes toxic when it continues for a long period of time and there is no caring adult present to mitigate the pain; abuse and chronic neglect, substance abuse by parent, repeated exposure to violence are examples (Center on the Developing Child 2009). Toxic stress can be most serious during the first three years, when brain plasticity is greatest:

> Abuse and neglect in the first years of life have a particularly pervasive impact. Prenatal development and the first two years are the time when the genetic, organic, and neurochemical foundations for impulse control are being created. It is also the time when the capacities for rational thinking and sensitivity to other people are being rooted—or not—in the child's personality. (Karr-Morse and Wiley 1997:45)

Trauma also has its impact on the developing brain.[6] Trauma is defined as an event in which the individual is frightened and is powerless. "Traumas are events involving threat or danger. They do not have to be actually violent. The perception that something terrible could happen can make the event traumatic" (Berliner 2013:4). Both physical child abuse and sexual child abuse fit this definition, as does witnessing violence. Being separated from parents when moved to out-of-home placement has long been recognized as a traumatic experience (Littner 1950). Almost all children in the child welfare system have experienced trauma. Most children recover from trauma within a short time after the event, and the presence of a concerned caregiver enhances the possibility of recovery. Some children do not and continue to suffer post-traumatic distress, manifested in behavior problems.

Complex trauma involves repeated exposure to two or more of these forms of trauma—abuse, domestic violence, or neglect—as well as severe caregiver impairment and school or community violence and affects core domains of functioning. "Complex trauma often leaves the child unable to self-regulate (that is, to control his or her feelings, cognitions, beliefs, intentions, and actions), to achieve a sense of self-integrity (that is, the feeling and belief that one is a unique, whole, coherent, and worthy individual), or to experience relationships as nurturing and reliable resources that support self-regulation and self-integrity" (Ford and Courtois 2009:16). Among the long-term effects are scholastic failure, unemployment, early pregnancy, substance dependence, domestic violence, chronic mental and physical illness, and health risk behaviors (Spinazzola et al. 2013). It is estimated that more than 70 percent of children in foster care meet the criteria for complex trauma (Greeson et al. 2011).

Children who experience trauma in the context of supportive and nurturing homes usually recover. Caregivers provide a sense of safety and help them understand what has happened. In an abusive or neglectful home or a home with family dysfunction, this support may not be available. Trauma-informed interventions have been developed in recent years to assist mental health professionals in helping children recover from trauma and to assist caretakers in providing the support that children need for this recovery. Unknown, however, is the degree to which the plasticity of the brain extends beyond early childhood, and whether distortions in the brain's organization can be corrected. Children who do not receive this support will continue to have difficulties with self-regulation and will present challenges to parents, educators, and the larger community.

ACES, described earlier, supplements our knowledge about stress and trauma and brain development with a confirmation that these early experiences have life-threatening consequences for adults. A major contribution of ACES has been the information that adverse experiences are cumulative—more such experiences, evidenced by a simple additive score, are associated with worse outcomes (Felitti et al. 1998).

The Struggle to Understand Abuse and Neglect

As child abuse and neglect were being discovered, early writers attempted to distinguish between them, ascribing particular characteristics to parents who abuse and other characteristics to those who neglect (Young 1964; Gil 1970; Polansky et al. 1981). As experience was gained in working with these families, it became apparent that more than one form of maltreatment was often present in a home. Ecological and developmental factors assumed more importance in thinking about cause, and the "medical model," ascribing cause to psychological deviance of the parents, became less useful.

Neglect Neglect is the most common of the forms of maltreatment, but it is perhaps the least well understood (Pecora et al. 2009) and the most difficult to impact (personal

communication, Kristine Nelson, 2007). In 2011, more than three quarters of substantiated reports of maltreatment concerned neglect (U.S. Department of Health and Human Services 2012), and it is the only category of maltreatment that is not declining (Sedlak et al. 2010). The need to provide services for low-risk neglect cases has long been recognized; over the years, one notes that whenever there is an increase in staff in a protective service agency, the proportion of neglect cases rises as workers have capacity to reach out and serve more families.[7]

Neglect is "primarily the result of an impoverished relationship between parent and child. The parent fails to meet the needs of an infant through lack of care, which then manifests in developmental consequences for the child and even death" (Scannapieco and Connel-Carrick 2005:38). Neglect of older children is also serious, though its consequences may not be as catastrophic.

The factors associated with child neglect are numerous. Family and environmental stresses and lack of family and community supports are often evident. Large families (four or more children) have historically been identified with neglect (Polansky et al. 1981; Giovannoni 1985; Nelson, Saunders, and Landsman 1993). NIS-4 found this still true (Seldak et al. 2010). NIS-4 reported that children who live in the poorest families (incomes under $15,000 per year) were seven times more likely to be neglected than other children; in a related finding, unemployment was found to be associated with neglect (Seldak et al. 2010). NIS-4 investigated the relationship of neglect and family structure and found children of single parents to be the most vulnerable, with children living with one biological parent and a cohabiting partner having the highest rate of neglect (eight times greater than a child living with married biological parents; Seldak et al. 2010). Parental substance abuse is also associated with neglect (US Department of Health and Human Services 2009)

Most research on neglect focuses on the mother's role, for women are viewed as the primary caretakers of young children. It is difficult at times to distinguish neglect from poor child care due to poverty. Roberts (2002) discusses the cultural misunderstanding and racism involved in labeling poor black mothers as neglectful. Swift writes of the "manufacture" of neglecting mothers through applying agency definitions to families living in poverty (Swift 1995).

Neglect has serious consequences. At its most severe, neglect of an infant or very young child can lead to developmental delay or even death. Profound neglect, as seen in the orphanages of some Eastern European countries, where children may have had minimal physical care but have no opportunity to interact with caregivers, can lead to an apparent inability to form social attachments, with consequent language and behavioral difficulties. A serious consequence of neglect is impaired attachment, which leads to poorer coping with the environment, with more impulsive behavior, and poorer problem-solving skills (Scannapieco and Connel-Carrick 2005). School-age children who are neglected and unkempt are often shunned by their peers, creating a social isolation that further distorts normal development. Neglect often occurs in concert with other forms of maltreatment, and the combined consequences, particularly among infants and young children, can have severe impact on child development.

Physical Abuse Pediatric radiologists working with X-rays in the 1960s were the first to recognize a pattern of multiple fractures at different stages of healing in the long bones of small children. The extent of this physical abuse of children was first documented in a national survey, in which 302 children were discovered hospitalized due to physical abuse (Kempe et al. 1962).

States responded in the next decade by passing laws aimed at protecting children from physical abuse; most of these laws mandated reporting of suspected abuse and granted the

reporter immunity from prosecution for slander. The passage of the Federal Child Abuse Prevention and Treatment Act in 1974 provided assistance to states for the development of child protection programs. Because the focus of concern was relatively narrow and dramatic, these laws enjoyed much public support. Publicity resulted in increasing numbers of reports of suspected abuse. For example, in 1971 in Dade County, Florida, after a campaign to educate the public about child abuse and the responsibility to report, reports of suspected abuse increased in one year from 17 to 19,120 (Lindsey 1994). Protective service workers were overwhelmed, there and in other states, and have remained overwhelmed ever since.

In 2011, states reported that 17.6 percent of substantiated reports were for physical abuse (U.S. Department of Health and Human Services 2012). Physical abuse is often easier to substantiate than other types of abuse, because a child's injuries are visible and can be identified as having been intentionally inflicted.

While agreeing that physical abuse is unacceptable, communities are less clear about determining where on the continuum between physical punishment and abuse intervention is warranted. Definitions of abuse rely on judgments and are culturally bound. Different cultural groups may have different ways of providing guidance and discipline. Abuse can be said to have occurred when parents have behaved in a way unacceptable to their community and when the child has received injury or is at serious risk of injury because of parental actions.

Large epidemiologic studies have identified circumstances associated with abuse, which seem to remain fairly constant over time: poverty, unemployment, a new baby, a child with disabilities, social isolation, fragile family structure (Gil 1970; Strauss, Gelles, and Steinmetz 1980; Sedlak et al. 2010). Children living with one biological parent and a cohabiting partner had ten times the rate of abuse of those living with two biological parents.

Physical abuse has serious consequences. The first to document this was Elmer, who followed a group of seriously physically abused children several years after the abuse and found that a high proportion of them had serious physical disabilities or had limited cognitive function due to head injuries occurring during the abusive episode (Elmer 1977). The violence of physical abuse and the helplessness a child feels mark it as trauma; traumatized children often develop symptoms of anxiety, aggression, depression, and/or academic impairment (Pinna and Gewirtz 2013). Thus emotional disturbance, often expressed as aggression, often follows physical abuse, even if the child is removed from the abusive home. This has become particularly evident as the foster parents and adoptive parents of children who were removed from their original homes after abuse, and placed as older children, have sought mental health services for their children.

Sexual Abuse Sexual abuse was not recognized as a community problem until the late 1970s; its recognition was largely due to the voice of the feminist movement. The feminist movement saw child sexual abuse and rape as related examples of inordinate male power in a patriarchal society and worked to bring both to public awareness. Early intervention for sexual abuse focused on girls; it was not until the 1990s that it began to be apparent that boys could also be victims of sexual abuse.

In 2010, there were 65,000 cases of substantiated child sexual abuse, about 9.5 percent of all substantiated maltreatment (U.S. Department of Health and Human Services 2012). As with other types of maltreatment, the reported and substantiated incidents doubtless represent only a small proportion of actual incidence—this may be particularly true for sexual abuse because of the guilt and shame involved. Both NCANDs and NIS-4 note a large drop in the number of sexual abuse victims between 1995 and the latest data collection, with the rate of sexual abuse per 1,000 children dropping by

about half (Sedlak et al. 2010; U.S. Department of Health and Human Services 2012). Though it has been evident during this time that sexual abuse cases were becoming a smaller and smaller proportion of protective service caseloads, there has been little publicity about this change. One would like to think that education aimed at helping children say "no," and at encouraging reporting, combined with community enforcement of criminal sanctions, has reduced the actual numbers of victimized children.

The characteristics of the children who are victims of sexual abuse differ from those of other types of abuse. Though maltreatment is generally fairly evenly distributed between boys and girls, most victims of sexual abuse are girls (Putnam 2003; Seldak et al. 2010). Though most victims of other types of abuse are young children, almost half of the victims of sexual abuse are 12 years of age or older (U.S. Department of Health and Human Services 2012). Though reporting rates are higher for those of lower socioeconomic status, retrospective studies indicate that child sexual abuse occurs with about equal frequency in all strata of society (Putnam 2003). Children with disabilities are particularly vulnerable, with almost double the risk of sexual abuse (Olafson 2011).

The characteristics of those who actually sexually abuse children have not been well defined. Most are heterosexual men. Though most perpetrators are known to their victims, the majority are not immediate family members or relatives (Olafson 2011). Family systems have often been cited as part of the explanation, with the mother often being identified as being distant from the daughter and unable to protect her. Feminists point out that this model blames the woman, when the man is the actual perpetrator. Olafson (2011) documents a repeated pattern of discovery of child sexual abuse, followed by a "backlash" orchestrated by middle- and upper-class men who raise doubts about the credibility of victims and the competency of helping professionals; this pattern, she writes, has had an impact on awareness of child sexual abuse and on funding for services.

Because the definition of child sexual abuse encompasses such a wide range of experiences, it is difficult to generalize about the consequences. Sexual abuse with contact, especially rape, has the greatest impact. In addition to the physical harm that can come to a child through sexual abuse, the emotional harm can be extensive. Sexual abuse distorts a child's developmental process, and this can lead to a devalued self-image, difficulties in relationships, and precocious sexuality. The relationship between child sexual abuse and depression is strong. Women experiencing any type of sexual abuse during childhood were about three times more likely than non-abused women to report drug or alcohol dependence (Olafson 2011). When abuse is severe and long lasting, disabling posttraumatic stress symptoms may result.

Emotional Maltreatment Though emotional maltreatment, sometimes called psychological maltreatment, accompanies almost all abuse and neglect, by itself it is less frequently reported and less frequently established than other forms of abuse. In part this is because of the linkage of child protective services with the legal system; unless psychological abuse or neglect has been severe enough to cause demonstrable harm to the child, either in physical or behavioral manifestations, it is difficult to prove in court. Psychological maltreatment accounts for only 9 percent of founded maltreatment cases (U.S. Department of Health and Human Services 2012). This has been relatively constant over the past fifteen years.

Psychological maltreatment takes different forms at different child developmental levels. As outlined by Gabarino, Guttmann, and Seeley (1986), it involves a "pattern of psychologically destructive behavior" that constitutes "a concerted attack by an adult on a child's development of self and social competence" (p. 8). Note the similarity to the description of complex trauma. The attack can take five

forms—rejecting, isolating, terrorizing, ignoring, and/or corrupting—and will be manifested in differing behavior at different child developmental levels. For example, rejecting behavior in infancy takes the form of rejecting the child's overtures so that formation of a primary attachment relationship is thwarted. In early childhood, the child is excluded from family activities. As the child becomes school age, the parent "consistently communicates a negative definition of self to the child" by belittling accomplishment, scapegoating, and use of labels such as "dummy" or "monster." In adolescence, the parent refuses to acknowledge the changing roles within the family, either infantilizing the adolescent, continuing to criticize and humiliate the adolescent, or, finally, expelling the adolescent from the family (p. 25).[8] The psychic destruction of consistent parental behaviors such as these is evident.[9]

Descriptions of parents who psychologically maltreat their children read much like descriptions of parents who physically abuse or neglect their children. Poverty, isolation, and substance abuse create strain in family life. Parents have not been adequately nurtured themselves as children and have poor role models and little to give. Parents have unrealistic expectations, which their children fail to meet.

Psychological abuse and neglect have serious consequences. Abuse, with its belittling, scapegoating, and isolating behavior, leads inevitably to struggles with self-esteem, to anger and possibly violence, to estrangement from family life. Emotional neglect has equally devastating consequences, particularly in infancy and early childhood. If a child's attempts at attachment are consistently rejected, the basis for distorted developmental patterns and lifelong difficulty has been laid.[10]

Domestic Violence

Family violence is not defined as a category of maltreatment by the Children's Bureau. It is, however, recognized as an adverse experience for children, and many protective service interventions for "risk of harm" document family violence. Prior to the feminist movement of the 1980s, family violence was largely unrecognized or, if recognized, thought of as a problem that should be handled within the privacy of the family. Feminists raised the consciousness of the community about the extent of family violence and the damage—both physical and emotional—that it could do to women.[11]

Domestic violence refers to the intimate context within which one partner is exposed to a pattern of assaultive and coercive behaviors. The violence may be physical, sexual, and/or psychological. Though there are instances of women as the aggressors in domestic violence, far more often women are the victims. Domestic violence occurs across all social strata and cultural groups, though its interpretation may differ from culture to culture. Estimates of prevalence vary depending on the sample and the definition of exposure to violence. The National Survey of Exposure to Violence reports that more than one in nine children were exposed to some form of family violence during the past year, including one in fifteen exposed to violence between parents (Hamby et al. 2011).

Domestic violence and child maltreatment are linked. Investigation of family factors from protective service caseloads, and studies that begin by identifying women who have sought help, yield an estimate that in from 30 percent to 60 percent of the instances in which either spousal violence or child maltreatment is identified, it is likely that both exist (Edleson 1999). Among families investigated for child maltreatment in a large, national study of child well-being, families in which domestic violence is present were found to have more risk factors such as primary caregivers with mental health issues, a history of recent arrest, and a history of childhood abuse or neglect. Children seen to be experiencing a high level of cumulative risk were ten times more likely to be placed in foster care (Kohl et al. 2005).

There is no question that children in violent homes are aware of the violence. A four-city

telephone survey asked mothers about their children's involvement in abusive episodes, and most mothers reported that the children were aware of the abuse. Children were reported to be drawn to the room as a violent episode began, but then to leave. About a quarter of the children called someone for help, and another quarter attempted to intervene physically. The more pervasive and violent the abuse, the higher the proportion of children involved. Family stability and the relationship of the abuser to the mother and child were factors influencing the involvement of the children (Edleson et al. 2001).

The extent of the developmental hazard to the child who witnesses abuse without being a direct victim is well documented. Studies measuring children's behavior through standardized mental health instruments have found that children who have been in violent homes display more externalizing problem behavior, more internalizing problem behavior, and less social competence. Not surprisingly, they display more anxiety and lower cognitive and verbal abilities. And, perhaps more worrisome, they display lowered self-esteem and less empathy (Peled, Jaffe, and Edleson 1995). More recent studies of brain development in young children demonstrate that the chronic stress and watchfulness of living in the midst of violence actually affects brain development (Carpenter and Stacks 2009). While research is limited, it seems that the degree of trauma—and developmental damage—from witnessing violence is dependent on age, the chronic nature of stress, and whether the child has a relationship with a person that is safe and dependable (Center on the Developing Child at Harvard University 2009).

The safe and dependable person in most of these families is the mother. Separation of children from their mothers and placement in out-of-home care thus removes a support that can help children process the trauma. Not all children respond in the same way to witnessing domestic violence; as with other trauma, the presence of a nurturing person can act as a cushion. On a hopeful note, recent evaluations of the capacities of victimized women have demonstrated that they can and do help their children cope with the trauma through increased nurturing (Letourneau, Fedlick, and Willms 2007; Casanueva et al. 2008). Any intervention by child welfare workers demands complicated decisions and new ways of conceptualizing child safety and family preservation.

Child Fatalities

The death of a child due to caretaker's abuse or neglect is a shocking and tragic event. Such deaths are relatively rare, though intense media attention tends to magnify the impact of each death. In 2011, 1,545 children were reported as having died as a result of maltreatment. This number has fluctuated only slightly in recent years. Most maltreatment occurs at the hands of one or both parents; this is true of 78 percent of fatalities (U.S. Department of Health and Human Services 2012).

Cause of Death Classification of the cause of death can be complicated. Statistics from the Children's Bureau report that many child deaths (36 percent) were associated with more than one type of maltreatment. Neglect, alone or in combination with other maltreatment, was responsible for 71 percent of the deaths (U.S. Department of Health and Human Services 2012). A study of fatal child maltreatment in Oklahoma over a 21-year period found a slight majority to be due to neglect and only 5 percent due to both abuse and neglect (Damashek, Nelson, and Bonner 2013). Data from a National Violence Death Reporting System focused on violence and found two thirds of the deaths to be due to abusive head trauma, and only 10 percent were attributed to neglect (Klevens and Leeb 2010). The cause of death is important only insofar as it suggests strategies to prevent future deaths.

Available statistics undoubtedly underestimate the number of fatalities, both because of child deaths that are attributed mistakenly to natural causes and because of lack of coordination of the many systems tracking child deaths.[12]

Coordination of reporting systems, so that police, health departments, and the child welfare department are all working together, has helped in the identification of fatalities due to maltreatment.

Increased use of interdisciplinary child fatality review teams perhaps offers the best hope for understanding the scope and nature of child fatalities and implementing appropriate prevention efforts. These are teams—usually with representatives from child welfare, police, the court and health systems, and other related disciplines—that review all child deaths that are not clearly from natural causes. Review teams seek to establish what happened and to build patterns in order to identify risk factors. The interdisciplinary nature of the teams permits many points of view to be explored.

Increasing study of fatalities has led to the discovery of certain common occurrences and to public education campaigns. Perhaps the most notable example is the recognition of the number of fatalities occurring when a baby or small child was shaken and the "NEVER SHAKE A BABY" campaign that resulted. This campaign provided new information to the public and has apparently had considerable impact.

Prior Reports of Maltreatment When fatalities due to maltreatment occur, they mobilize a community and often lead to criticism of child welfare workers. It is assumed that the child welfare system should have been able to protect the child. However, these are not always children who have been failed by child welfare agencies; two thirds of the child fatalities had no previous contact with child protective services though in some of these cases there may have been referrals regarding another child in the family (Putnam-Hornstein et al. 2013).

However, what is known raises questions about the ability to detect high-risk maltreatment reports. There is relatively little research on the association of child fatalities with prior maltreatment, though in a longitudinal study Jonson-Reid, Chance, and Drake (2007) found a significantly higher rate of death in a sample of poor children with a confirmed report of maltreatment when compared with a comparable group with no report. Analysis of data on fatalities from the child welfare data system shows that of those who were known to the system, family preservation services were provided to only 9 percent of the families of children who died in the five years preceding their deaths, and only 1.4 percent of the children had been in foster care within the past five years (U.S. Department of Health and Human Services 2012). Unknown is the number of families in which a child died that was known to the child welfare agency and receiving community-based family strengthening services. Nor do we know how many families were reported to the child welfare system, perhaps had brief contact during an investigation but were not linked to services.

Characteristics of Children Younger children are at substantially higher risk of fatal maltreatment; various research studies estimate that about 90 percent are younger than 5 years of age. In 2011, according to federal statistics, 42 percent were less than 1 year of age, and 81 percent were under 4, an age span during which children are relatively helpless, are easily injured, and tend to be out of the community's view (figure 1.2).

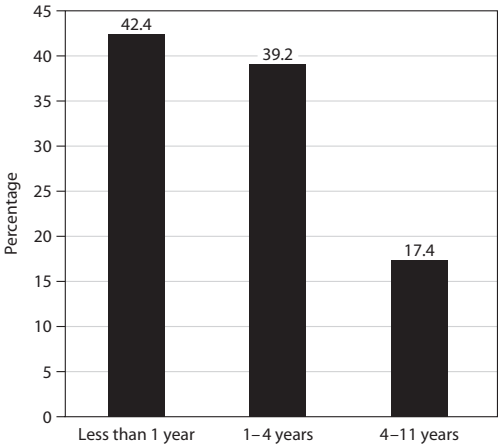

FIGURE 1.2. Fatalities and age of child *Source:* NCANDS 2012 (U.S. Department of Health and Human Services 2012)

Risk factors that have emerged from continuing research are male gender, compromised child health, young maternal age and limited education, and poverty. African American and Native American children are overrepresented. Children of single mothers have been consistently overrepresented, though this may be because there is opportunity for unrelated men to reside with them (Putnam-Hoirnstein et al. 2013). Poverty and substance abuse are common (Douglas and McCarthy 2010). Child behavior considered to be "provoking" and prior out-of-home placement are also factors in child fatality cases (Chance and Scannapieco 2002).

Risk Factors If we could predict which families were most likely to severely injure or kill their children, preventive services might be put in place. However, the risk factors that lead to child fatalities are imperfectly understood. It might be expected that risk factors in a family in which a child has died because of maltreatment would be greater in number or intensity than those that lead to severe, nonfatal abuse. It is not clear that this is so; a review of research shows that the characteristics of families in which a child dies are very similar to many more ordinary families that abuse or neglect. It has been suggested that "homicide is not simply an extreme form of interpersonal violence. Rather, homicide is a distinct form of behavior that requires a distinct explanation" (Gelles 1996:85–86).

A beginning at identifying predictive factors may be found in a study in which protective service cases that led to a death were compared with cases that did not. The researchers discovered that some risks are so evident that protective service workers took action to protect the child, thus preventing a fatality. But they also were able to isolate variables that were predictive of maltreatment-related deaths in cases that did not seem terribly serious overall; these variables were related to the quality of the connection between the caregiver and the child, caregiver abilities and skills, and child vulnerability (Graham et al. 2010). DeHaan (1997) also found that families in which a child died resembled families judged to be low risk. Family hostility toward, or lack of cooperation with, intervention in an investigation of maltreatment has also emerged as a risk factor (Chance and Scannapieco 2002).

The best predictor of future behavior seems to be past behavior, and thus prior severe injury or death of a child in a family is definitely considered a risk factor. In a longitudinal study of 7,438 poor children, divided into a group with a maltreatment report and a group without, and followed since 1995, there was a significantly higher rate of death in the group that had been reported (Jonson-Reid, Chance, and Drake 2007). The finding was consistent with a longitudinal study of children born in California between 1999 and 2006; the findings of this study were that children with a prior allegation of maltreatment died from intentional injuries at a rate that was 5.9 times greater than that of unreported children and also faced a heightened risk of death from unintentional injury (Putnam-Hornstein 2011).

Research is continuing to explore the factors associated with child deaths from abuse or neglect. The task is difficult. Child fatalities are rare. When child welfare services do have the opportunity to work with a family, the difficulty lies in distinguishing the families who are not able to protect a child but who look so much like other families referred for child maltreatment. There is great need for more information to inform risk assessments of the potential for fatal maltreatment and to indicate the type and intensity of supportive services that might prevent the fatality.

Critical Issue: Poverty

Poverty is extensive, both in urban and rural settings, and particularly among families of color. Social workers have often been instrumental in bringing recognition of this poverty to the larger community. Government policy and private philanthropy have tried, with little success, to eliminate poverty.

One out of every five children in the United States lived in poverty in 2010. It is important to understand what this means in the lives of children. Poverty impairs children's health and emotional and intellectual development. Many of the problems identified in this chapter are found to a much greater extent among families who are poor. Poverty denies children opportunities for adequate nutrition and health care, for family stability, for good schools and the opportunities that education can create, for specialized services to meet developmental needs and to nurture talent, and for opportunities to establish themselves in the workplace. In short, poor children do not start with a level playing field.

In examining poverty, one wants to know how extensive poverty is, what its impact is on children and families, and what can be done to remedy the problem. The latter question involves a consideration of what causes poverty.

Defining Poverty

In any discussion of poverty, it is necessary to have a point of reference to determine who is poor. Poverty in the United States is defined as having less than the minimum amount necessary to provide food, shelter, and basic living necessities. In 2013 this was an annual income, for a family of four with two children, below $23,550.[13] This is not an arbitrary figure, but an income level calculated to be the minimum amount a family needs to survive, and is known as the poverty line.

One of the tasks undertaken by social workers, very early in the development of the profession, was finding a way to define poverty and determine its extent. Charles Booth, who studied the extent of poverty between 1876 and 1893 in London, recognized that poverty was variously interpreted, and that in order to count the number of poor, one needed a solid definition. He developed the concept of the poverty line, which has been used ever since.[14]

In 1963, Mollie Orshansky, an economist at the Social Security Administration, developed a complex set of figures that account for many elements that affect family expenditures, important among them the size of the family and the number of children under 18 years of age. The measure was developed from the Department of Agriculture's pricing of a nutritionally adequate diet "designed for temporary or emergency use when funds are low"—often referred to as the basic "food basket." Based on information from an earlier survey, Orshansky multiplied this minimal nutritional level by three to obtain the minimum income a family needed. She presented the poverty threshold as a measure of income inadequacy, not adequacy (Fisher 1997). The federal government adopted this as the official measure of poverty in 1969. This measure, with occasional slight modifications, continues to be used today.

As the economy is not static, it is necessary to adjust the poverty threshold to account for changes. Inflation affects the poverty line. To accommodate changes in the value of the dollar, it was decided to adjust the poverty threshold for changes in pricing. The basic "food basket" was thus indexed to the Consumer Price Index (Fisher 1997).

Other adjustments have been more difficult. As a nation becomes wealthier, there is a general increase in the standard of living; for example, a car is now a necessity in rural areas, most houses have electricity, and a television is no longer considered a luxury. The poverty line does not reflect any changes on this dimension, but review of adjustments over time shows that it consistently rises (Fisher 1996). Rent now tends to absorb more than the third of family income that it did in the 1960s. Work expenses have risen; changes in employment patterns and family structure mean that expenses of transportation and child care are necessary. Advances in medicine have raised the costs of medical care. The cost of living varies widely by region. The "food basket" approach does not adjust for these changes. At the same time, supplemental programs, such as food stamps and tax credits, which could lift families out of poverty, are not counted.

A supplemental poverty measure taking account of these elements was released by the Census Bureau in 2011. The cost of a basic set of goods was calculated and adjusted to meet geographic differences. In a major philosophical shift, poverty was defined in relative terms as those "at or below the 33rd percentile of the expenditure distribution" of any geographic area (Short 2012). This way of measuring showed that 18 percent of the children in the United States were living in poverty.

The Extent of Child Poverty

By either measure, in 2012 approximately one out of every five children in the United States live in families with income less than the federal poverty line and almost half of these children are in extreme poverty (Children's Defense Fund 2013). [15] When a similar poverty measure first was applied in 1959, it was estimated that 25 percent of American children were living in poverty. The War on Poverty of President Johnson had its impact; in the 1970 census the estimate was that about 15.8 percent of children were living in poverty (Kadushin 1980). By 1996, the percentage had climbed to 20.5 percent, where it remained until the economic expansion of the late 1990s. Poverty among children then began to drop slightly and reached a low of 16.9 percent in 2007. With worsening economic conditions, the proportion of children in poverty drifted upward to its current 22 percent (U.S. Census Bureau 2011b).

Poverty is not equally distributed among the races; in 2011, while only 11.9 percent of white children were poor, 33.1 percent of Hispanic children and 35.7 percent of African American children lived in families with income below the poverty line. Estimates for Asian/Pacific Islanders are similar to those for white children, about 11.1 percent living below the poverty line (U.S. Census Bureau 2011b). With its sampling methodology, the Census Bureau draws too small a sample of Native American families to estimate poverty; other sources report that 36 percent of Native American children lived in poor families in 2011 (Addy, Engelhardt, and Skinner 2013). These figures are even more disturbing than the total poverty rates for all children. They indicate that more than a third of the African American, Native American, and Hispanic children in our country live at or below the poverty line (figure 1.3).[16]

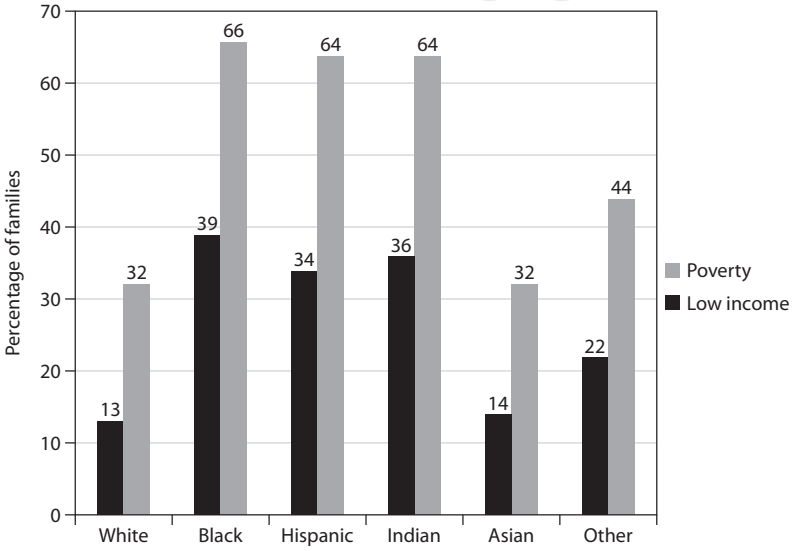

FIGURE 1.3. Families with inadequate income by race and ethnic group *Source:* National Center for Children in Poverty (Jiang 2014)

The National Center for Children in Poverty notes that the current poverty line does not reflect the amount a family needs to meet basic needs in today's world. That figure is about twice that of the poverty line. Almost two thirds of Hispanic, African American, and Native American children live in families with less than this income. One third of white children live in these low-income families (Addy, Engelhardt, and Skinner 2013).

Young children are also overrepresented among the poor. Children under 6 years of age are 33 percent of the child population; however, 51 percent of children under 6 lived in low-income families (Addy, Engelhardt, and Skinner 2013). These very young years are, of course, the time when the developing child is most dependent on adequate nutrition and consistent care.

Family structure affects poverty. The median income of female-headed households, with no husband present, was $23,343 in 2009. The reader will note that this is just below the poverty line for a family of four. Fifty-six percent of poor children live in single-mother families (Children's Defense Fund 2013).

Work does not necessarily lift a family out of poverty. Two thirds of poor children live in a family in which at least one family member is working. Fifteen percent of poor children have a family member who is working full-time, year around (Children's Defense Fund 2013). This, of course, at least in part explains the great increase in households where both parents are working outside the home and explains why single-parent, female-headed households are the most likely to be poor.

Many families cycle in and out of poverty, while others remain poor for many years. A third of the children in the United States live in poverty at some point during their childhood. Ten percent of children are persistently poor, spending at least half of their childhood years in poverty. African American children are seven times more likely to be persistently poor (Ratcliffe and McKernan 2010).

The Causes of Poverty

From the beginning of the social work profession, there have been attempts to identify the causes of poverty. And the results of inquiry have been inconclusive. Certainly there are systemic issues that make it difficult to earn an adequate income. There is not really equality of opportunity; some young people enter the adult world with poor education from substandard schools, with poor training in the habits that create successful employees and businesses, and with handicaps of immigrant status, racism, and a culture of poverty to handicap them. But there is also an individual component. We all know of young people from difficult backgrounds who have done well in the economic world. Ambition, determination, willingness to practice skills—these are some of the attributes of these people. Usually, but not always, education is the route through which they advance.[17] And, of course, there are those who are poor because of mental or physical disabilities or illness.

The first inquiries about the causes of poverty followed closely upon Booth's work (described in preceding paragraphs) that demonstrated its extent. The initial work of the Charity Organization Societies focused on the immediate causes of poverty, attempting through individual case study to determine what caused the need for assistance. This approach tended to identify subjective causes of poverty—individual characteristics and habits. Amos Warner in 1894 published "American Charities: A Study of Philanthropy and Economics." In it he presented the results of collated findings for nearly 28,000 cases of relief applications investigated by Charity Organization Societies in 1887. His work shifted the emphasis to the faulty structure and injustices of society as a whole:

> Untrained charity workers who come immediately in contact with the poor are very prone to take short-sighted views of the causes of poverty. On the other hand, those who study the question from a philosophical standpoint are apt to lay too

much stress on the influence of institutions or environment.

Each of these types of observers has, indeed, seized on a portion of the truth; the questions of character are very far from insignificant, but so long as it is impossible to measure accurately all the forces within and without the individual which tend to push him above or below the line of economic independence, it will be necessary to study the combined operation of character, circumstance, and environment in accounting for his failure.

The question most commonly in the minds of those who undertake to investigate the causes of poverty by a system of case counting is this: is poverty a misfortune or a fault? No full answer to the question can probably be worked out by scientific methods. (Warner 1894; reported in Zimbalist 1977:54)

In the United States, there has always been a belief that careful planning, hard work, and industry would be rewarded with a comfortable standard of living. The early social welfare workers, such as Jane Addams, were influential in promoting an alternate view of poverty as a consequence of the forces of society, against which, too often, the individual could do little. The oppression of the poor by those better off became an important idea in some parts of the social work profession, and the battle against oppression that social work has always waged became also a battle against poverty.

In the current era, the data about those who are poor give some indications of what causes poverty in our society at this time. As shown in figure 1.3, families of color are heavily represented among those families with inadequate income. The reasons are multiple and well known. Families headed by a woman are also likely to be poor, reflections of many years of wage discrimination. Those families dependent on minimum-wage jobs are most likely to be poor, children of immigrants are likely to be poor, and low levels of education are associated with poverty (Children's Defense Fund 2013). Wage stagnation is a factor; real wages have, for all but the wealthiest, declined in the past twenty years (Mishel and Shierholz 2011). Unemployment of a wage earner also contributes to poverty; the unemployment rate varies with the economic fluctuations of the economy. These data indicate structural problems in our society that prevent some families from being economically successful.

The Community Response to Poverty

Attempts to solve the problem of poverty have been based at least in part on the explanation for poverty current in the community. In general, the community response to poverty, outlined in the following pages, seems to reflect the idea that the individual is responsible for his or her economic status, but that the community will act to prevent extreme suffering.

Preserving Families for Children It was a major advance for children when in the late-nineteenth century the idea arose that poor children should be cared for in their own homes rather than in institutions. Current patterns of income assistance for children began in the late 1800s, with the provision of income assistance to "worthy poor" families—families whose moral standards matched those of the givers of assistance, such as those who were widowed or physically disabled. The Charity Organization Societies pioneered this approach, searching for the causes of poverty and ways to eradicate it, but at the same time giving funds for maintenance of the home to those deemed worthy—mainly widows who had young children at home and who were determined "respectable" (Zimbalist 1977).

The era of social reform that led to the child labor laws and the juvenile court also led to recognition of the need to preserve the homes of children whose parents were unable to support them. The first resolution adopted by the White House Conference on the Care of Dependent Children, called by Theodore Roosevelt in 1909, "laid great stress on providing a means for keeping children in their own homes" (Abbott

1938b:230). The same conference declared that children should not be placed into out-of-home care "for reasons of poverty alone" (Pelton 2008:26). This has become a touchstone for social workers dealing with the placement of children in out-of-home care.

Recognizing the plight of women left with small children when their husbands died or deserted them, some states developed mothers' pensions. These also were allowances for the maintenance of "worthy" women and their children. However, the hardships of the Great Depression in the 1930s increased the numbers of the destitute and revealed the inadequacy of private and local relief efforts. Though dated in its conception of family roles, Julia Lathrop's dictate of 1919 remains valid today:

> Children are not safe and happy if their parents are miserable, and parents must be miserable if they cannot protect a home against poverty. Let us not delude ourselves: The power to maintain a decent family living standard is a primary essential of child welfare. This means a living wage and wholesome working life for the man, a good and skillful mother at home to keep the house and comfort all within it. Society can afford no less and can afford no exception. (Bradbury 1962:8)

Aid to Dependent Children Aid to Dependent Children (ADC) was established by Congress in 1935 as part of the Social Security Act to provide income assistance to women and children without a male wage earner in the household. It was a response to the Great Depression, when private charities no longer could meet the need of families. Its intent was to enable women to stay home and care for their children, both because this was an accepted model of family organization and because in a time of great unemployment, the government did not want women taking scarce jobs from men. ADC was a means-tested program, which means that assistance was available only to those who could prove that they did not have adequate income, and that as family income rose, the amount of aid would decline. The program contained both state and federal funding, and the amount of assistance varied among the states. In the 1950s, when it was thought that the availability of assistance to single women with children, but not to intact families, was causing fathers to desert, the law was changed to provide assistance to families without adequate income, regardless of family composition, and the name was changed to Aid to Families with Dependent Children (AFDC). The legislation produced a guaranteed income "floor" for children, contained the idea of an entitlement to a basic level of income, and suggested that poverty was not always the consequence of individual failings. It was restrictive, and payments were low enough that there was no incentive not to work.

Twenty years later, a majority of women were no longer staying at home caring for their children while their husbands supported the family. Working women, struggling to organize their households, care for children, and meet the demands of full-time jobs, increasingly contrasted their position with that of women receiving income from the government and staying home with their children. Swelling welfare roles raised public concern about women who had children while very young and unmarried, with no plans for support other than public child welfare. It was feared that welfare payments were supporting unwise decisions or even encouraging immoral sexual activity.

The first major response to these changing times occurred at the federal level in 1988 with the passage of the Family Support Act, which introduced the idea that the recipient of AFDC support had a responsibility to seek paid employment. Job training programs, child care, and help in finding work were introduced. However, changes in numbers of welfare recipients were modest, and the low-paying jobs to which recipients moved too often did little to alleviate their poverty.

Welfare Reform: Temporary Assistance for Needy Families By 1995, determination to end expenditures for AFDC had hardened. Little attention was paid to statistics about the short time most recipients used AFDC benefits, statistics about births to single women across income categories, or about the difficult time women with limited education and no job skills had in earning a living wage. The time for welfare reform had come. The stated goals of this reform were to promote work and to strengthen the two-parent family structure.

Thus, in 1996, Congress passed the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA). The idea that poverty was the result of economic forces shifted; public policy once again focused on individual improvidence as the cause. The reforms essentially changed an entitlement to income assistance into a program that set strict limits on the number of years a family could receive assistance, while offering training programs and child care to make employment possible. It is not a generous program; benefits in 2009 were less than the real dollar amount that AFDC payments had been in every state (Children's Defense Fund 2011).

States were given considerable flexibility in establishing benefits. Temporary Assistance to Needy Families (TANF) programs provided limited income assistance with varied time limits, combined with job training. The focus shifted from determination of income eligibility to counseling to promote employment. Families would be allowed two years of assistance before employment was expected. The legislation set a limit of five years of total lifetime assistance. States were allowed to provide exemptions to these rules for no more than 20 percent of their welfare rolls, and incentives were offered to states for success in moving families off welfare rolls. The federal government block-granted the money for TANF assistance, so that states were free to implement the program in any way consistent with the goals of the legislation. In many instances, states set timelines more stringent than that of the federal government.

In the first years of the program's implementation, aided by a strong economy, there was good success in moving families from welfare to employment: in 1992, 5.1 million families were receiving income maintenance payments; by June 2000, the number had dropped to 2.2 million. Though many of these jobs were low wage, family income initially increased (U.S. Department of Health and Human Services 2000). It is, however, difficult to support a family with a single low-paying income from forty hours per week of work. Ten years after TANF began, the percentage of children in poverty dropped only slightly, to 18 percent. By 2011 it had again risen to 20 percent (U.S. Census Bureau 2011b). Welfare reform did not reduce poverty to any significant extent; families traded low welfare payments for low-paying jobs.

Despite the strong economy, many states supplemented private sector job programs with public employment, seeing it as a temporary expedient to teach job skills and serve as a bridge to full employment. These programs were expensive, providing wages as well as child care, and were not intended to be permanent. As recession took hold of the economy in 2008 and later years; there were fewer jobs and less state money to provide public employment. Additionally, the first families to move from welfare were probably those with the most education and the greatest number of job skills. There is limited data on what has happened to those with little education and no work experience, in an economy not producing many new jobs, when they reached the limits of the time they can receive assistance.[18]

More than 3.4 million children receive TANF grants; this is a 58.8 percent reduction since August 1996 when major changes were made in the federal welfare program. TANF supports do not lift a family out of poverty; in all states the maximum benefit for a three-person family is less than half the federal poverty level. The range is from 11 percent in Mississippi to

48.4 percent in Alaska (Children's Defense Fund 2011). These astoundingly low payments reflect the deep fear that has always been part of income maintenance programs—the fear that if income assistance were adequate, parents would opt to receive it instead of working.

The Social Security Act Another source of income for children has been the Social Security Act. The Survivor's Insurance program, established in 1939, provides benefits to dependents of a deceased worker who has paid Social Security taxes. Benefits are indexed to inflation. When the program was enacted in 1939, at a time when death was the usual reason for the absence of a father, it was expected that survivor's insurance would eventually replace the needs-based Aid to Dependent Children, thus providing an income floor to which all children would be entitled.

Also administered by the Social Security Administration is Supplemental Security Income (SSI), established in 1972. This program provides monthly payments to needy blind and disabled persons. Many states supplement these payments. In recent years, children with emotional disabilities have been considered eligible to receive SSI. Relatively few children receive SSI, but these are the children with many needs who will often require extensive services.

Using the Tax System The Earned Income Tax Credit also serves as a source of help to many low-income families with children. Families with low earnings receive credit against their income tax for each dollar they earn. With increasing income, the credit becomes smaller. If a family with low income does not have to pay taxes, the credit is refundable. In 2010, 3 million children were brought out of poverty by the Earned Income Tax Credit (Children's Defense Fund 2013). This is an approach to the provision of income assistance that is favored by many because it assists poor families through the relatively straightforward means of the tax system and avoids stigmatization. It has lifted more children out of poverty than any other single program.

The Child Tax Credit has also been of help to many working families. This is a credit of a specified amount for each child in a family. In 2010, this program helped to lift more than 1.4 million children out of poverty (Children's Defense Fund 2013). Designed to help low-income families, the tax credit allows families below a certain income level to claim a credit of $1,000 per child, with the amount they can claim diminishing as income rises. In 2011, the phase-out of the credit began at $110,000 for couples filling a joint return; above that amount, the credit was reduced $50 for each $1,000 of additional income.

Child Support Enforcement A major federal and state effort also developed in the 1980s to help mothers obtain child support from absent fathers. In part, this arose from the same civic outrage that fueled the welfare reform of 1995. In 1984 and 1988, amendments to the federal child support law made it more likely that child support would actually be collected. Requirements that employers deduct court-ordered child support from paychecks have been particularly useful. However, such requirements do little if the father is unemployed or employed as a casual laborer and seeks to evade payment.

Nutrition Supplements Federal programs have also attempted to supplement children's nutrition. The major program is food stamps, available to families who can prove low income. These vouchers, currently loaded onto cards similar to debit cards, can be used at the store to buy food items. As part of the welfare reform in 1995, qualifications for obtaining food stamps became more stringent.

Other federal nutrition programs target children of low-income families directly. The Special Supplemental Nutrition Program for Women, Infants and Children (WIC) targets pregnant women and their children under age 5 and has been very successful in reducing

malnutrition during a crucial period of child development. Subsidized school breakfast and lunch programs can also have a major impact on children's physical development and on ability to learn. Because they target children directly, these programs have been less affected by recent cutbacks than have cash assistance programs.

The Impact of Poverty on Children

Many of the issues that affect children, reviewed earlier in the chapter, have links to poverty. Poverty is the usual cause of hunger and homelessness. As is illustrated in figure 1.4, most children who are abused and/or neglected live in families struggling with poverty. This is particularly true of neglect, and least true of sexual abuse. It should be noted that poverty alone does not cause poor parenting—many poor families are good parents. Poverty simply makes parenting much, much more difficult.

Over time, many studies have demonstrated links between children's poverty and various measures of achievement. "The risk for poor relative to non-poor children is 2.0 times as high for grade repetition and dropping out of high school, and 1.4 times as high for having a learning disability . . . 1.3 times as high for a teenage out-of-wedlock birth, and 2.2 times as high for experiencing violent crime" (Duncan and Brooks-Gunn 2000:188).

Early childhood is the period during which income seems to matter the most—which makes the statistic that young children are most at risk of poverty even more alarming. Single working mothers struggle with the daily demands of their lives and may have little time or energy left for a young child. Cognitive disparities emerge as early as 9 months of age between children of low and higher incomes, and many children never catch up (Children's Defense Fund 2011).

Children go to school in their own neighborhoods. Poor children often go to schools that have fewer resources than those in more affluent neighborhoods. Buildings are often older and less well kept, expenditure per pupil is lower,

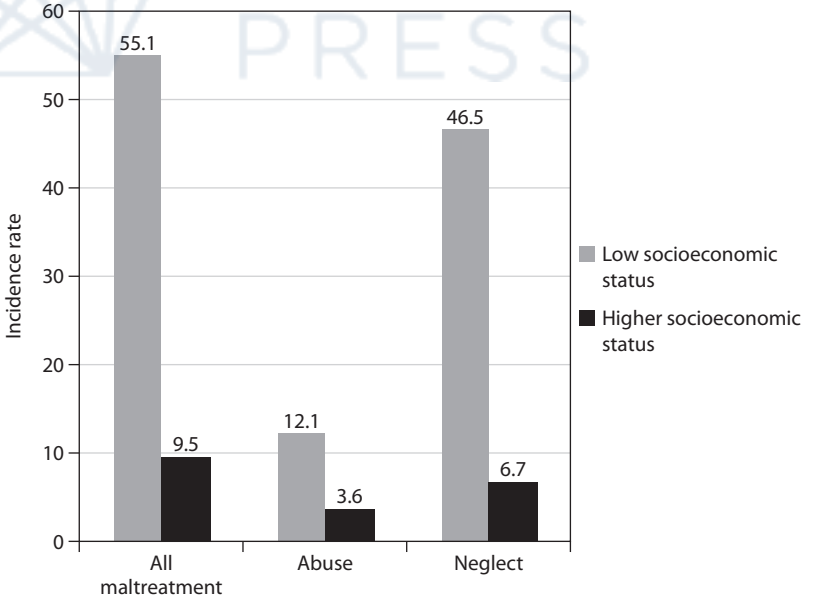

FIGURE 1.4. Incidence rate of maltreatment by socioeconomic status *Source:* NIS-4 2010 (Sedlak 2010)
Socioeconomic status is defined as income below $15000 annually, participation in a poverty program, and/or failure to graduate from high school.

and parents have few resources to supplement those of the school. Expectations may be lower (Children's Defense Fund 2011). The number of homeless children has increased each year since 2005 (U.S. Conference of Mayors 2008). In addition to the lack of security that homelessness entails, it also means frequent changes in schools, creating an additional negative impact on children's academic achievement.

Poor children live in poor neighborhoods, neighborhoods that are often violent, and lack resources such as playgrounds, libraries, and after-school activities. These are the neighborhoods filled with the temptations of alcohol and drugs and the possibility of adequate income through illegal activities. This is the pathway in adolescence to poor outcomes—dropping out of school, becoming involved in illegal activity and/or substance abuse, becoming a parent before being ready to take on that responsibility.

One of the consequences of poverty for children is a greater probability of abuse or neglect. It is easy for those who are poor to become involved with child protective services, as box 1.2 illustrates.

BOX 1.2

One of the families we knew was a single mother with five children; the oldest was nine, the youngest a toddler. She came to the attention of protective services when a neighbor called the police to complain that the children had been left alone. The police arrived to find the children indeed alone. By the time their mother returned from the grocery store with supplies for Thanksgiving dinner, the children had been taken to foster care. They were returned to her care after the holiday weekend, on condition that the children be properly supervised.

Thus began a saga that continued for several months and was not resolved when we last interviewed the mother. Ms. G had some clerical skills and experience and could find low-wage employment. When she was not working, she gave good care to her children. When she had work, she had difficulty arranging child care. Sometimes she left the children alone for short periods of time when the alternative was to miss work; then the neighbors would report to protective services that the children were again unsupervised. Sometimes she was late to work in order to wait for a caregiver or missed a day's work when things really went wrong. She would miss enough work, or be late often enough, that she would lose her job. She would stay home and care for her children, and the protective service worker would feel that all was going well. Then the TANF worker would be insistent that she look for new employment, and the cycle would begin again.

Data from a national study of the incidence of child maltreatment has consistently shown that both abuse and neglect are more frequent among families of low socioeconomic status—defined as low income or less than high school education. Children in low socioeconomic households were more than three times as likely as other children to be abused and about seven times as likely to be neglected (Sedlak et al. 2010). The reasons for this linkage are speculative. It is probable that the stresses of living in poverty create tensions in the home. Lack of income prevents poor parents from accessing supplementary child care, either to supervise children while they work or do errands or to provide needed respite. It is also probable that characteristics that make it difficult to parent, such as physical disabilities or mental illness, also make it difficult to earn an adequate income. And it is quite possible that poor parents are reported more often to child protective agencies—they live in crowded neighborhoods, use public clinics for health care, and often share housing with extended family.

Finally, recent research is indicating that poverty, through hunger and chronic physiologic stress, may impact brain development. Hungry children cannot learn effectively because chronic undernutrition harms their cognitive development during this critical period of brain growth. They lack the energy to experiment with and learn about social interactions. Recent research has shown that pervasive stress during infancy and early childhood can alter hormone production, resulting in altered

neural functions, and even changing the architecture of regions of the brain that are essential for learning and memory (Center on the Developing Child at Harvard University 2009; Evans and Schamberg 2009). Thus children who experience chronic poverty have a biological obstacle to success.

Knitzer (2001) writes of a population dependent on public welfare and affected by depression, substance abuse, and domestic violence. She suggests that welfare reform and a national goal of seeing that every child enters first grade ready to learn may provide a framework for positive intervention in the lives of these families. Early childhood services (Head Start, child care, preschool, home-visiting programs, family resource programs) can provide a point of entry, as can welfare reform, substance abuse programs, family violence services, or mental health services. So can child welfare protective services. Coordination of these services will not be easy—it will demand examination and reconciliation of the differing value bases, as well as integration of diverse federal programs with different sources of funding and, at the local level, the blending of funds for different services.

The negative impact of poverty on family life and child development has been well documented. Poverty, and the compromises that are made in the attempt to cope with poverty, may well underlie subsequent negative experiences and poor outcomes.[19] It would appear that the eradication of poverty might be a major contributor toward attaining better outcomes for our children.

The economic assistance provided to poor families has never been generous; there has always been concern that income support that would provide an adequate standard of living would result in the families failing to take responsibility for supporting their own children and becoming dependent on the community. The structural problems that prevent families from supporting themselves have not received as much attention as would be expected.

Conclusion

These, then, are some of the major social problems that affect children and with which the community has grappled in the past three hundred years. It is hoped that this rather long and involved chapter has established the connection between the social conditions that the community defines as a problem and those services that the community wants to see provided. It has also shown how social workers (or, before the profession was established, the social welfare worker) discover and document problems through direct work with those suffering. It is evident that, repeatedly, community problems have been discovered by those working directly with affected families and have been brought to the attention of the community so that some action could be taken.

Considerable space has been devoted in the chapter to child abuse and neglect, as the protection of children is the particular provenance of child welfare services. The recognized types of maltreatment have been defined, their incidence documented, and the consequences to children explored. Considerable space has also been given to family violence and to poverty, two adverse conditions affecting many of the families with whom child welfare services interact. Maltreatment has been identified as a traumatic event, as is witnessing family violence, while poverty is a chronic stress that has negative consequences on child development. The presence in children's lives of multiple traumas (polytrauma) has been explored.

This review of the conditions that prevent children from reaching their developmental potential has set the stage for the following chapters, in which the policy framework of services to strengthen families and communities and to foster optimal child development is developed. Social work has been deeply involved in the development and implementation of those policies.

This mission of social work is complicated. Today, communities have become so heterogeneous that the voice of the community is often

split. Perceptions of need vary. There is little consensus about whether the responsibility for building family supports rests with the community or whether the individual family unit should be self-sufficient. There is a gap between what society says it wants to do and what it will fund. These are critical issues for children. In order to work effectively with the community and within the community, the social worker and child welfare practitioner need to understand these forces and how to work with them to create change.

NOTES

1. Much of the discussion of the juvenile court is based on the work of Charles Shireman, professor emeritus of the University of Chicago, who developed a section on the juvenile court for the first edition of this book.
2. Probation services are used instead of incarceration when it is thought that the community does not need protection from the offender and that the offender will benefit from continued presence in the community. They consist of community supervision by a probation officer who monitors the activities of the offender to the extent reasonable by policy, provides guidance and counsel, and endeavors to see that the offender has opportunities to function in law-conforming ways.
3. This was a case in which a juvenile had been sentenced to a long term in a juvenile institution because of obscene telephone calls made to a neighbor. The sentence was so obviously out of proportion to the offense that it was seized upon by critics of the juvenile court, and the case became the vehicle through which the U.S. Supreme Court established the rights of juveniles to the protections of the adult system.
4. For more information, see the website of the National Fatherhood Initiative (www.fatherhood.org).
5. When the trajectory of children referred for investigation for child maltreatment was followed, a distinct pattern emerged. If substance abuse was part of the allegation, the complaint was more likely to be substantiated, and foster home placement and adoption were more likely. In one cohort, 79 percent of maltreatment allegations involving substance abuse were substantiated, as were only 18 percent of other allegations. Children were much more likely to be placed in foster care: 61 percent versus 17 percent. And of infants placed in foster care, 47 percent are adopted, while 25 percent return to parents, a pattern that is reversed for infants whose parents are not involved in substance abuse. Additionally, the parents of substance abusing children were more likely to be reported in subsequent years (Wulczyn 2009).
6. Writers do not consistently differentiate between toxic stress, polytrauma, and complex trauma.
7. The complexities of identifying neglect are well illustrated in Jeanette Walls's autobiographical *The Glass Castle* (New York: Scribner, 2005). In that book, the reader will find the importance of the father in the family as his nurture cushions the impact of the mother's neglect and the deterioration of the home as his drinking increases.
8. Gabarino, Guttmann, and Seeley (1986), *The Psychologically Battered Child* (pp. 23–43), provide descriptions for each of the five dimensions, illustrated with case examples. The recognition of emotional abuse and/or neglect becomes clear in reading them.
9. An excellent description of the experiences of a psychologically abused child, and the adult she became, is found in Jane Hamilton's 1988 novel, *The Book of Ruth* (New York: Anchor Books).
10. This is most dramatically seen in the children in the orphanages of Eastern Europe, who have become known to the Western world in the past twenty years. These children were fed and their physical needs met in a minimal way, but their emotional needs were profoundly neglected. We know best those who were adopted and brought to the United States or other Western European countries. Though they have manifested multiple developmental difficulties, anecdotal reports suggest that the attention and nurture of adoptive homes has been remedial for some. The research that will follow the development of these children into young adult years should soon be available.
11. It is difficult to imagine a violent home. Ellen Quindlan's novel *Black and Blue* (New York: Random House, 1998) conveys the anxiety and despair of such a home.
12. See Lindsey (1994), *The Welfare of Children*, or Costin, Karger, and Stoesz (1996), *The Politics of Child Abuse in America*, for thorough discussions of these numbers.
13. Higher poverty guidelines are in effect in Alaska ($29,440) and Hawaii ($27,090), reflecting higher costs of living in those states.
14. Charles Booth was a wealthy merchant who attended lectures at Toynbee House, a settlement house in London. While there, he heard one lecturer state that a quarter of the people in London were poor. Booth thought this "incendiary" estimate unlikely, and set about to determine the correct percentage. The task consumed seventeen years and produced fascinating records of the

lives of the poor in London in the late 1800s. The correct percentage turned out to be 30.7 percent (Zimbalist 1977).

15. Extreme poverty is defined as the family having half or less of the amount of income established as the federal poverty guideline.
16. An indicator of the impact of poverty emerges when one notes that these percentages are similar to the disproportionate percentages of juveniles in institutions for delinquent youth and children in foster care.
17. Two recent presidents of the United States, President Clinton and President Obama, are examples.
18. Jason DeParle's *American Dream: Three Women, Ten Kids, and a Nation's Drive to End Welfare* (New York: Penguin Books, 2004) is a reporter's investigation of the way in which three families on welfare manage the transition from AFDC to TANF. It is compelling and informative.
19. Lisbeth Schorr in *Within Our Reach: Breaking the Cycle of Disadvantage* (New York: Anchor Press, 1988) details many of these compromises and their impact on children. She also examines programs that have had positive impact in these circumstances.

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2

The Child Welfare Services System

WITH KATHARINE CAHN

Do I contradict myself?
Very well then I contradict myself.
(I am large, I contain multitudes.)
—Walt Whitman, "Song of Myself"

Even though the term *child welfare services* may bring to mind one specific agency, in fact the child welfare system is a complex system of agencies, community partners, family members, and faith leaders all working together to keep children safe in nurturing permanent families. In this chapter the system is explored, documenting the multiple influences on services to children. The chapter ends with a discussion of establishing safe, permanent homes for children and supporting their well-being—the goal of child welfare services.

Safety, Permanence, and Well-Being

A first priority of child welfare services is attending to the safety of children. When there is abuse or neglect in a home, safety can be achieved by strengthening parenting capacities and/or by offering protective supports in home so that parents are able to parent without maltreatment. If needed, the child can be removed to a safe placement, usually foster care.

However, foster care is a flawed solution. The trauma of separation from parents is significant. Children may experience frequent moves while in foster care, further aggravating the trauma of the original separation. Foster care lacks the emotional security of a legally established home. Making foster care placements short and seeing that each child has a permanent home is thus a secondary goal of child welfare services. A permanent home can be the original home of the child, an adoptive home, or a foster home that assumes guardianship. This goal has been labeled "permanency." It is relatively easy to measure in outcome studies and is explored in some depth at the end of this chapter.

Over the past decade, there has been increasing evidence that children in the child welfare system were having difficulties as they matured. New research, such as the Adverse Childhood Experiences Study (ACES), and brain-imaging technology underscore the importance of childhood experiences in shaping adult lives. In response to this information, child welfare services are now putting increased emphasis on child well-being, a third goal of child welfare services. The Administration on Children, Youth, and Families has identified four domains of well-being: cognitive functioning, physical health and development, emotional/behavioral functioning, and social functioning; to these, healthy family relationships and attachment to a caring and reliable adult could be added (State Policy Advocacy and Reform Center 2013). These domains are more difficult to measure but have been included in the Child and Family Services Review (CFSR) and the National Survey of Child and Adolescent Well-Being (NSCAW), both discussed later in the chapter. With this focus on well-being, child welfare services are stepping out into a wider and more complex environment.

The Role of the Child Welfare Agency

The principal provider of protective, remedial, and permanency services is the public child

welfare agency, working within the oversight of juvenile dependency courts. Interaction with the legal system and the court is constant. As parents may have multiple problems impinging on child safety, workers must be able to build case plans involving income maintenance, schools, doctors and hospitals, disability services, substance abuse programs, domestic violence services, the mental health system, the public health system—the list continues. Informal supports such as family members and cultural and faith communities are also included in planning for safety, permanence, and well-being. The effective interface of systems and communities is difficult but necessary if we are to be effective in producing best outcomes for children from families with multiple needs.

The system begins with community responsibility for the identification of maltreatment and depends on an interlocking set of cooperating agencies throughout the case to bring about child safety, permanence, and well-being, all under management of the child welfare agency and the watchful eye of the courts. Though the phrase *child welfare* is sometimes used to refer to one public or tribal agency, in reality the child welfare system is just that—a system—not the province of one agency alone.

Levels and Branches of Government in the System

In the delivery of child welfare services, one sees the traditional interaction of the legislative, judicial, and executive branches of government at federal, state, county, and tribal levels. The federal legislative role is seen in laws that shape delivery of services throughout the country (laws to be reviewed later in this chapter). State legislatures supplement these laws to fit the needs of the state or create laws to align with federal mandates or programs. The laws are reviewed by the judicial system as those affected challenge them in court; most review is at the state level, but major issues may reach the federal court system. The judicial system also provides checks and balances at the case level. The executive branch (including agencies that report to the executive such as child welfare) is responsible for carrying out the intent of the laws. At the federal level, the Department of Health and Human Services develops regulations and policy and the incentives for states to follow the policy. At the state level, the child welfare agency carries out the law, as it investigates complaints about abuse and neglect and provides remedial services to children and families. In some states, the administration and delivery of child welfare services happens at the county level of government, with state-level supervision or oversight.

Native American tribes are sovereign nations with a government-to-government relationship with the U.S. government, and many tribes have developed their own child welfare systems. Funding comes from the federal Bureau of Indian Affairs, from federal programs, and sometimes from a state. Tribes are now also eligible to receive child welfare funds directly from the federal government.

These levels of government—across three branches and up and down the levels—create a complex pattern of interaction. A great strength of the system is that as states develop their own patterns, natural experimentation takes place, and best practices are identified. The weakness lies in the complexity, lack of consistency, and rigidity that can ensue.

The Federal Role in Shaping Policy

The federal role in the development of child welfare services has been one of trying to ensure adequate services across the states. The Children's Bureau has been a leader in the development of child welfare policy. Legislation has played a key role; the approach of the federal government has been to establish funding that is available to states that meet standards set in policy. As federal policy evolves, funding streams also change to provide incentives for states to move in new policy directions. The federal government also initiates and funds special projects at the national level and promotes

innovation by allowing states to waive federal rules when they can demonstrate the effectiveness of new approaches to practice.

The Children's Bureau

The 1912 founding of the Children's Bureau, the first federal agency with a social policy agenda, was a great achievement of the Progressive movement. Under strong leadership, the bureau encouraged public responsibility for social problems. Its research and advocacy began with attention to child labor and maternal and child health and continued with support for mother's pensions, public health clinics, juvenile courts, and, beginning in the 1920s, the establishment of public child welfare agencies (Lieberman and Nelson 2013).

The passage of the Social Security Act and its authorization of public funds for staff and administration of public child welfare agencies created the opportunity for the founding of public child welfare agencies. Many in the private sector were, however, worried by this increased public presence, fearing both the regulation and the competition that might come from the public sector. In order to pass the child welfare amendments to the Social Security Act, a compromise was necessary: funds for the establishment of public child welfare agencies were to be restricted to largely rural states, where there was limited presence of private agencies (Rosenthall 2000). To this time, the public presence in child welfare is stronger in the Western than in the Eastern states, which rely more heavily on private agencies for case management and direct services. Grants for research, demonstration and training, and, more recently, demonstration research projects under the Title IV-E waiver program have been an important component of the Children's Bureau leadership.

Legislation

Federal legislation, reviewed in more detail later in this chapter, has impact on the policy directions of the states. For example, with the Child Abuse Prevention and Treatment Act came legislation to encourage mandated reporting of child maltreatment and services to assist children and families where there had been abuse or neglect. With the Adoption Assistance and Child Welfare Act of 1980, federal legislation pushed states toward family preservation services and timely planning. The Adoption and Safe Families Act (ASFA), passed in 1997, was an expression of a renewed emphasis on safety as a central concern and of the assertive commitment to move children promptly toward permanent homes even if this means adoption rather than family reunification. The Family Connections to Success and Fostering Adoptions Act of 2008 expanded options for permanent family connections.

Funding

Federal money comes to the states through specific programs established by law as well as through grants for specific purposes. Though federal agencies do not directly control state agencies, by setting the parameters under which federal funds can be claimed for state and tribal programs, federal legislation and initiatives have considerable influence upon state policy. State agencies make every attempt to draw down federal dollars and tend to shape their programs to follow federal funding parameters. In recent years, as part of the devolution of federal authority to the states, some human service funding streams have been capped and turned over to the states. However, Title IV-E, the largest federal funding stream for child welfare, remains uncapped as of this writing. That means the federal government will pay a share of the cost of federally allowed services to all federally eligible children. What services are allowed and which children are eligible is a matter of federal policy.

Reformers object to the restriction of uncapped federal funding to foster care alone, arguing that funds now invested in foster care may be more effectively spent in early intervention and prevention. To address that, some states have a capped federal grant in some areas

of service delivery in exchange for a waiver of the restriction of federal funding tied to foster care–related services. This provides states the opportunity to offer a more flexible and seamless continuum that can include preventive or in-home work. A rigorous research component is required of these waiver demonstration grants, and the program must be at least cost-neutral (that is, not cost more than business as usual—for example, placement in foster care—would have cost for the same time period). These federal waiver demonstration grants (often referred to as IV-E waivers) have been an important source of innovation in recent years, leading to changes in federal policy.

Quality Assurance and Review

With the passage of ASFA, the Children's Bureau took a stronger role in overseeing the quality of child welfare in states by instituting a periodic review to capture performance information about specific child welfare systems and practices in each state. In the first two rounds of implementation, this review, the Child and Family Services Review—CFSR—contained benchmarks for success across the three program goals of permanency, safety, and well-being. It also assessed key program or "systemic" factors (such as a licensing program, training for staff and caregivers, and quality assurance and data systems) that make up an effective child welfare program. After a state self-assessment on these factors, an on-site review of a sampling of cases took a deeper look at how services were delivered to selected children and youth. In response to findings of these reviews, a Program Improvement Plan was required to address areas needing improvement.[1] National benchmarks have been set, and there are penalties for not achieving these goals. The CFSR has now been conducted twice in each state and is undergoing review and redesign at the federal level; however, the new nature and focus of these reviews was significant.

This federally implemented quality assurance process introduced a change in the nature of federal oversight from a process audit, examining the contents of case files, to a more collaborative relationship intended to determine what was actually happening with children and families and to help states build the capacity to serve children. The process required extensive collaboration and input from courts, community members, service providers, tribal members, advocates, and foster parents and other caregivers, as well as the children, youth, and families in care. The process of these reviews signaled the federal understanding that child welfare is a collaborative process and must draw on the expertise of many to gain positive outcomes for children.

While no one factor can be identified in the slow process of child welfare reform, many believe that the CFSR has been instrumental in drawing attention to such practice issues as the need for flexibility in response to reports of maltreatment, the need for permanence for older youth, the need to engage fathers and paternal relatives, and the importance of strong agency-court collaboration. Juvenile courts were funded to conduct parallel court improvement programs. Quality supervision is an important way to improve child welfare, and improving supervisory skills was the focus of many states' program improvement plans.

The CFSR also moved many states to stronger attention to data and to quality assurance. The majority of states met the standard for quality assurance systems and state information systems. Many states used their program improvement plans to strengthen their data systems and to establish some form of quality service review that looked at cases more comprehensively, often following the pattern of the federal reviews. This attention to data and quality assurance helped shape more accountable child welfare systems at the state and local levels.

Safety and permanence were outcomes of child welfare services that could be measured from the administrative data systems described in the following paragraphs. Well-being of children, the third outcome, was more difficult to

measure. The CFSR focused attention on this outcome and provided measurable indicators. Rather than simply assessing the needs of children in the system, CFSR pushed states to assess whether they have provided services or linked families to services to meet these needs.

The well-being indicators of the CFSR can be described as follows (Webb et al. 2010:xxii):

- Families enjoy enhanced capacity to provide for their children's needs (indicators are assessment of needs and provision of services to families, child and family involvement in case planning, caseworker visits with children, caseworker visits with parents).
- Children receive appropriate services to meet their educational needs (indicators are assessment and provision for children's educational needs).
- Children receive adequate services to meet their physical and mental health needs (indicators are provision for physical health needs, including dental health, and provision for children's mental and behavioral health).

While all of these outcomes are important, the outcome of enhancing family capacity is particularly interesting. The collaborative tone that it sets is echoed in the new alternative response protocols being developed for response to reports of abuse and neglect (described in chapter 3), and the federal benchmark may have pushed the quite rapid adoption by states of this type of response. The emphasis on work with the child's family will also direct protective service workers toward working diligently to make it possible for the child to remain at home, thus avoiding the trauma of separation from family in foster care placement.

Though there is discussion about the adequacy of the CFSR as an outcome measurement (see, for example, Schuerman and Needell 2009), its impact in shaping practice is important. For many years, there has been pressure on child protective services to become less authoritarian and to use more of the collaborative techniques of social work practice. Change is slow, but the emphasis of the CFSR is creating additional pressure.

Development of Data Systems

Data are essential to the management of any system, necessary for the tracking of funds and for policy making, and necessary to know whether the system is working equitably and effectively for children. Accurate data about the characteristics and service needs of children is particularly important as federal policy initiatives impact state patterns of service development, and as child welfare agencies themselves develop patterns of purchase of services from private providers.

In 1993, the federal government published rules for the State Automated Child Welfare Information System (SACWIS). One part of this system is the National Child Abuse and Neglect Data System (NCANDS), which reports data required from the states by the Child Abuse Prevention and Treatment Act, as amended in 1996, as well as other data reported by the states. Another part is the Adoption and Foster Care Analysis and Reporting System (AFCARS) whereby states receiving federal funds must report certain data to the federal government every six months. The state SACWIS systems contain basic data about child protection, family preservation and support services, foster care and adoption, and independent living. The plan is that they are to interface with income maintenance data systems and to "provide for intrastate electronic data exchange and data collection systems" (House Committee on Ways and Means 1998:811). There is federal match as an incentive for the development of the systems and financial penalties for failure to participate. Though it took time, all states now submit data to the federal systems. Reports are available at the Children's Bureau website (www.acf.hhs.gov/programs/cb), making national data easily available.

A second source of data is the National Survey of Child and Adolescent Well-Being (NSCAW). This national, longitudinal study of children at risk of abuse or neglect or in the child welfare system collects data from parents, children, and service providers and presents a comprehensive picture of the experiences of these children. The first NSCAW assessed 5,501 families and children reported to protective services for a fifteen-month period starting in October 1999; contact occurred at referral and again at 12 months, 18 months, 36 months, and 59–96 months. Families were followed regardless of service history. A second NSCAW includes 5,872 children sampled from child welfare investigations occurring during a fifteen-month period starting in February 2008 and will follow a similar pattern. With its focus on well-being, NSCAW data sources are assessments of children, interviews with children age 7 years and older, interviews with caregivers (usually parents), interviews with caseworkers, and teacher questionnaires. The data include many standardized measures of child development. Data from this rich source is available in a series of reports that can be accessed at www.acf.hhs.gov/programs/opre/research/project/national-survey-of-child-and-adolescent-wellbeing-nascaw. Because of confidentiality, access to the original data is limited to accredited researchers; the data are stored at the national Data Archive on Child Abuse and Neglect at Cornell University.

National data on the incidence of child abuse and neglect is also available from the National Incidence Studies of Child Abuse and Neglect (NIS). Four of these studies have been conducted, reporting incidence in 1980, 1986, 1993, and 2005 (Sedlak et al. 2010). The reports are based on a nationally representative sample population, and inquiries are made not only of protective service workers but also of other investigatory personnel and of professionals in schools, hospitals, and other major agencies. Respondents are asked about child maltreatment that they have observed and reported and about maltreatment observed and not reported. The attempt is to ascertain the actual incidence of maltreatment, not just reported maltreatment.

National data concerning adoptions is difficult to obtain because there is no system that aggregates data on public and private adoptive placements. Flango and Caskey (2005) detail their complex and painstaking efforts to count total adoptions; they reported 127,000 domestic adoptions in 2001 (not including stepparent adoptions). The U.S. Census counts adopted children, including stepparent adoptions. A national survey of adoptive parents was completed in 2007 and offers probably the most complete picture of adoptive families available (Vandivere, Malm, and Redel 2009). Yearly trends in adoptions from foster care (37 percent of all adoptions) are reflected in the AFCARS data. The U.S. State Department maintains immigration records on international adoptions (25 percent of all adoptions). There is no system that counts private domestic adoptive placements.

Advocacy agencies are another source of national-level data. For example, the Children's Defense Fund provides extensive yearly reports on indicators of child well-being, and the National "Kids Count" initiative, funded by the Annie E. Casey Foundation, offers state-level data. Reports from both organizations are published or can be found at http://datacenter.kidscount.org/. Some states also provide yearly reports to the public on certain aspects of their protective service and foster care systems.

It is possible to work with this mix of data, focusing on information that comes from reliable sources and is in agreement with data from other sources. However, the lack of a comprehensive national data system has for decades proved an impediment to policy makers and the providers of child welfare services. The maturing of the SACWIS data system is a major step forward.

The Legislative Framework

The legislative framework of child welfare consists of those laws that have been enacted in the

attempt to resolve the social problems described in chapter 1 and to guarantee stable, nurturing homes to children. The history of federal legislation, from the New Deal in the 1930s through the 1980s, has been one of increasing movement toward federal standard setting in child welfare services. Congress believed that if federal funds were to be spent, there should be federal oversight and control. The movement was reversed in the 1990s, with increasing emphasis on state-level development and control of child welfare programs. The main vehicle for this change (sometimes called "devolution," for the devolving of authority to states) has been the federal block granting system, in which states are given limited blocks of money for specific needs and challenged to develop programs that will meet the unique needs of their own citizens within that budget. This shift in focus is evident in income maintenance, child care, family preservation, and family support, all programs that have been block granted.

Clearly, the federal-state partnership is an important determinant of the shape of local child welfare systems. The following review identifies major legislation that has shaped the delivery of child welfare services. The implementation of the legislation is described in chapters focused on protective services (chapter 3), adoption (chapter 8), and the transition to adulthood (chapter 9). There is, of course, a great deal of additional legislation with which those working in particular facets of child welfare will need to be familiar.

Child Abuse Prevention and Treatment Act of 1974

As was described in chapter 1, in the 1960s physical child abuse was recognized by the public after the publicizing of the "battered child syndrome" (Kempe et al. 1962). One response was the passage of the Child Abuse Prevention and Treatment Act of 1974 (CAPTA), which provided an organizing framework to help states develop programs to protect children who were abused or neglected. It provided funds to assist states in developing systems that encompassed mandated reporting of suspected child abuse or neglect, public social service departments to investigate reports, and systems to keep track of substantiated cases of maltreatment. CAPTA also established the National Center on Child Abuse and Neglect (now the Office of Child Abuse and Neglect).

Reporting CAPTA established mechanisms for the reporting of suspected child abuse and neglect, mandating state establishment of means for this reporting. All citizens were encouraged to report any maltreatment that they became aware of. Additionally, in most states, certain professionals were designated as mandated reporters, meaning that they must report any knowledge of child maltreatment. All reporters are given immunity from prosecution for libel.

A continuing problem with reporting, and with centralized data collection, has been the definition of maltreatment. The laws of the fifty states tend to differ, sometimes markedly. This makes it difficult to compile meaningful national statistics. The imprecision of definitions of maltreatment has also led to difficulties in interpreting the laws to the public, to criticism of child protective agencies for not acting in cases of perceived maltreatment, and probably to underreporting due to uncertainty about what should be reported. The issue of defining child neglect has been particularly problematic.

Intervention CAPTA provided financial stimulus for the development of methods of identifying and treating child abuse and neglect, but the design, testing, and implementation of treatment programs to address parental problems at the root of the abuse or neglect or to help children heal has been left to the various states and is not well funded. Thus, there is wide variety in the approaches used. In response to increasing concern about the prevalence of drug use among families who abuse or neglect children, a 2001 addition to the law has demanded

that protocols to attend to the needs of infants affected by parental drug use be developed and implemented and that a "plan of safe care" be developed. Concern about the impact of early experiences is reflected in a 2004 amendment requiring that children under 3 years of age, who have been substantiated for abuse or neglect, be referred for a developmental assessment. An extensive Information Memorandum[2] was released in 2012 to expand the public understanding of the "well-being" mission of child welfare and to call for more attention to treatment of the trauma associated with abuse, neglect, and/or separation from family (U.S. Department of Health and Human Services 2012c).

Prevention The reporting laws of the Child Abuse Prevention and Treatment Act have received a great deal of attention, but the more expensive development and funding of programs aimed at prevention of child abuse and neglect has not been emphasized. At the same time that mandated reporting necessitated the commitment of the resources of child welfare agencies to the investigation of complaints, it diverted resources from prevention programs. While the evidence base is growing, their effectiveness has been difficult to demonstrate; the prevention of a low-incidence behavior is difficult to document.

The Title XX amendments to the Social Security Act authorized payment to the states for services that would prevent maltreatment, prevent placement in foster care, and provide appropriate placements when needed. These funds were limited to children already receiving Aid to Families with Dependent Children (AFDC) or Social Security disability payments. In 1981, this funding was converted to a block grant, allowing states to spend with fewer restrictions, but capping the amount available. In 2008, the funding was expanded to include all children in need of protection.

National Center on Child Abuse and Neglect CAPTA established the National Center on Child Abuse and Neglect, which became a center for the collection of data and a leader in shaping prevention services through the provision of grants, consultation, and national conferences. Moved into the Children's Bureau as the Office of Child Abuse and Neglect, it continues to draw national attention to the need for prevention at the level of community and family. However, it does not have service dollars to administer in funding such prevention efforts and provides leadership primarily through educational and research efforts.

The new awareness of child abuse, and the establishing of protocols for dealing with it, led to a major change in child welfare services. Before, these services had been broadly concerned with the welfare of children and families. Now, focus narrowed to the protection of children, often by placement in out-of-home care.

The Indian Child Welfare Act of 1978

The Indian Child Welfare Act (ICWA), adopted by Congress in 1978, was intended to end a history of attempts forcibly to assimilate Native American children into mainstream society and to remove them from their tribal homes and cultural roots. From the 1800s on, federal policy was to remove children to boarding schools, where they were taught the language and ways of the dominant U.S. culture, and where the attempt was to "eradicate the 'Indianness'" in young people (Mannes 1995). In 1958, the Bureau of Indian Affairs and the Child Welfare League of America established an Indian Adoption Project, in which many of the league's private agency members participated. The goal of this project was the removal of children from the poverty and perceived neglect of the reservations and the adoptive placement of these children, usually with white families. These transracial placements fit the earlier Bureau of Indian Affairs policies of educating Native American children in the mainstream white culture; the placements were also congruent with the goal of racial integration, which was a goal of the civil rights movement of the time.

Ten years later, this project had placed 395 Native American children (Mannes 1995). A follow-up study stated that the children seemed to be developing well in their adoptive homes and that adoptive parents were satisfied (Fanshel 1972). The research focused on the development of the adopted children and did not address the legal and cultural issues of American Indian or Alaskan Native sovereignty and tribal continuity. In testimony for passage of the Indian Child Welfare Act, these policies and practices were referred to as "cultural genocide," a strategy in the colonization of tribal nations by the U.S. government.

A study conducted by the American Association on Indian Affairs in 1969 showed that in states with large Native American populations, between 25 and 30 percent of the Native American children had been placed for adoption with white families, and that Native American children were much more likely to experience out-of-home placement than other children (Mannes 1995). This loss of their children was devastating for the tribes and for many tribes threatened extinction through the loss of language, culture, and connection to subsequent generations (hence the term *cultural genocide*). More information about current work by tribal advocates and adult adoptees of this generation to find and reestablish their tribal ties can be found under the search terms "Lost Birds" or "split feathers."

As a result of the War on Poverty, tribal governments were increasingly administering human service programs. With the passage of ICWA in 1978, they gained child welfare responsibilities, though funding did not follow. The act gives the tribal court exclusive jurisdiction over Native American children who live on reservations, and, when a child is living off the reservation and removed from his or her home, mandates notification of the tribe and gives the tribal court the right to take jurisdiction. The act calls child welfare agencies to make active efforts to place children with family, tribal members, or members of another tribe before moving to non-tribally approved homes. Placements with non-native families are allowed when approved by the tribe. These provisions apply in child custody proceedings such as dependency decisions, foster care placements, attempts to terminate parental rights, and pre-adoption and adoption placements (Jones 1995). The law applies to all children who are eligible for enrollment as members of a federally recognized tribe, and the determination of membership is made according to the rules of each tribe (Jones 1995).

The implementation of (or failure to implement) ICWA has been a matter of considerable controversy. With its primary focus on the preservation of tribal ties, at times its application has seemed to conflict with mainstream culture views of the best interest of the child. The legal requirement to prioritize a child's tribal membership and culture over other aspects of his or her culture (white, Hispanic, African American) can be misunderstood. State courts face very difficult decisions when tribal eligibility is discovered late in the decision-making process, long after a child has been placed with (and grown attached to) a non-tribally approved foster or adoptive home. It can be a difficult decision to remove a child from a long-standing foster placement, but this is legally supported if the child's tribe believes removal is in the best interests of the tribe and child, including the opportunity to learn and be raised by his or her own nation.

Advocates contend that resources have not been provided to tribal programs to develop robust child welfare services, nor have tribes been provided economic and family supports to reduce the need for child welfare. Advocates document that state child welfare programs and courts have consistently failed to follow the requirements of ICWA including training for workers on why it is important. The need for difficult and heart-wrenching decisions later in a child's journey in placement would be avoided if the law regarding tribal placement, tribal notification, and active efforts were

followed early on in every case. The federal act remains an important legal tool to ensure justice and cultural continuity for tribes and tribally enrolled children.

The Adoption Assistance and Child Welfare Act of 1980

The Adoption Assistance and Child Welfare Act of 1980, passed two years after ICWA, provided a policy framework focused on preventing long stays in foster care through family preservation or timely move to adoption. It mandated that reasonable efforts be made to prevent placement, that each child have a case plan, and that periodic case reviews take place for children in foster care. It also authorized subsidies to remove financial barriers to adoption. The emphasis of the act was on timely permanency. Periodic case reviews were designed to maintain a sense of urgency around a foster child's need for stable permanent family, while ensuring that reasonable efforts would be made to keep children with or return children to families. By assigning courts the oversight role for child welfare agency decision-making, this act brought child welfare agencies and courts into much closer collaboration, a pattern that continues to this day.

Title IV-E of the Social Security Act was created to provide fiscal incentives for states to implement the new procedures. It is essentially funding for foster care; adoption subsidies also come from this source, as do funds for Chafee Independent Living programs. Though the intent was to fund the provisions of the new child welfare legislation, in actuality increasing amounts of federal money have been devoted to foster care payments rather than to family support.

The Adoption Assistance and Child Welfare Act recognized the importance to children of a permanent home and, in establishing procedural requirements that prioritized keeping children with families or timely decision making regarding return home or adoption, ensuring that children did not "drift" in foster care. It established a policy framework for child protection and foster care services. Despite language regarding the importance of family ties, it reified the historic model of "rescue and place" by providing funds only for the placement and maintenance of children in foster and adoptive homes and little for work with children while with their original caretakers.

The Adoption and Safe Families Act of 1997

The Adoption and Safe Families Act of 1997 (ASFA) provided structure within the policy framework of prior legislation. It named children's safety as the first priority of child protective services, and with this priority it set parameters for the paths of children through the child protective services system. A second goal of ASFA was to expedite permanency planning, moving children more rapidly to decision points around reunification with family or adoption. It provided funding for the Court Improvement Program and for research and training programs.

The legislation set a time limit for a child's stay in foster care, saying that when a child has been in placement for fifteen of twenty-two months, the state must petition the court to terminate parental rights, except when the child is placed with relatives or when there are compelling reason not to file such an action. The court decides whether services have been provided to enable the child to return home. ASFA thus sets a time limit on the "reasonable efforts" required for parents to be able to care for their children. Also important is the mandate for concurrent planning; that is, planning for adoption at the same time that attempts are being made to reunite children with their original families.

ASFA also provides that in aggravated circumstances, the court may decide that efforts to rehabilitate the home for the child are not required before moving to termination of parental rights. Such circumstances include the most extreme cases, such as a parent having caused the death of another child through abuse or neglect, a parent having seriously injured

any child through maltreatment, a parent having starved or tortured this child, or the child being abandoned. Again, the intent is to identify families to whom the court will not return children and to move these children quickly toward adoption by relatives or other adults.

Reflecting a changing climate, relatives are in this legislation viewed as extended family. Some jurisdictions license extended family as foster homes. With changes in federal rules allowing federal subsidy of guardianships as well as adoption, child welfare agencies have begun to help relative families seek guardianship as a way to resolve the permanency of the child without termination of parental rights. In all cases, the question of equity of supports across foster home, guardianship, family court guardianship, and adoption can be an issue.

Adoption is identified as a desirable path to permanency for those children who cannot return to their original homes. The shortened timeline prior to termination of parental rights, re-authorization of adoption subsidies, and the authorization of "adoption bonuses" to states that increased the number of adoptions all focused on this solution. This thrust toward adoption was enhanced by President Clinton's 1996 initiative, Adoption 2002, which established bonuses for states that increased their numbers of adoptions.

The practice implications of ASFA became apparent in the following decade as the number of adoptions of children from the foster care system doubled in the first ten years after its passage. In 2011, more children were leaving foster care for adoption than in 1995, but a smaller proportion was leaving foster care to return to their own homes. The question must be asked whether too many children now are being rushed toward adoption whose families might have been able, given more time, to take them back.

Children who have been in foster care have had difficult experiences prior to placement and are likely to have emotional and behavioral problems. One is concerned about the willingness of the child welfare system to accept responsibility for provision of post-adoption services to stabilize these families and about the capacity of the child welfare system to make these services available to any family that needs them.

The Multiethnic Placement Act of 1994 and the Interethnic Adoption Provisions Amendment of 1996

The Multiethnic Placement Act (MEPA) may be viewed as a legislative attempt to increase the numbers of adoptive homes for children of color, many of who in 1994 were remaining in foster care for very long times. It may also be viewed as an attempt to increase the numbers of very young children available to white couples who wish to adopt. It is certainly an expression of legislative desire that children be moved quickly to permanent adoptive homes.

MEPA represents the most recent episode in a long debate about transracial adoption, which, in the United States, usually means the placement of a child of color in a white adoptive home. In 1975, the National Association of Black Social Workers issued a strong statement condemning transracial adoption and promoting within-race adoption matching. Transracial adoption ceased almost immediately, its prohibition generally becoming unwritten policy within child-placing agencies. Continued lobbying by organizations of adoptive parents and by persons who wished to adopt and a stream of research demonstrating that the outcomes of transracial adoptions were much like other adoptions led to the passage of MEPA.

The stated intent of MEPA was to decrease the amount of time that children of color wait to be adopted. It accomplishes this by preventing discrimination in matching children and prospective parents on the basis of race, color, or national origin and encouraging the recruitment of foster and adoptive homes that can meet the needs of waiting children. This law was strengthened by an amendment passed in 1996, the Interethnic Adoptive Provisions

Amendment (IEPA), which explicitly prohibits denying a person the opportunity to become a foster or adoptive parent on the basis of the race of the applicants or the race of the child. The Indian Child Welfare Act supersedes MEPA in the case of Native American children, due to the priority for the preservation of tribal nations.

Independent Living Initiative of 1986 and Foster Care Independence Act of 1999

In the 1980s, studies documented the difficulties youth were having after discharge from foster care (Zimmerman 1982; Festinger 1983). In response, in 1985 Congress created a pilot program to help youth make the transition from foster care to adulthood; this became the Independent Living Initiative of 1986. Independent living programs provided an array of services designed to give these youth about to exit foster care the skills they needed to become productive members of the adult world. Funding for independent living programs was capped, and states reported it was not sufficient to meet the needs of all youth in care.

Studies in the 1990s documented continued difficulties of young people discharged from foster care and demonstrated the need for increased help (Courtney and Piliavan 1995; U.S. Department of Health and Human Services 1999). Evaluation of independent living programs revealed that almost 40 percent of eligible youth did not receive services (U.S. General Accounting Office 1999).

In response, Congress passed the Foster Care Independence Act of 1999, which superseded the earlier legislation. This act established the John E. Chafee Foster Care Independence Program.[3] This legislation increased federal funding to help support youth until they reach the age of 21. In addition to an array of services, states were authorized to provide room and board funds. Medicaid coverage was extended to age 21 for those in independent living programs. Chafee educational funds will pay college tuition. In using these additional resources, states are required to ensure that each young person makes plans for the transition from foster care and is aware of the benefits of the independent living program. States are also required to collect outcome data in a systematic manner and to have youth advisory boards, elevating the importance of youth voice in planning at the systems level.

Fostering Connections to Success and Increasing Adoptions Act of 2008

Perhaps in reaction to the emphasis on adoption in ASFA, the Fostering Connections to Success and Increasing Adoptions Act approached the issue of permanency with an emphasis on kinship connections. Several provisions support placement of children with relatives, including the provision of assistance to states in subsidies for relatives who become guardians of children. Family Connection grants invest in efforts to find family, engage extended family in planning for children in care, and provide support for children living with relatives. Continuing a federal commitment to adoption, the legislation also increases incentives to states to find adoptive homes for children in foster care and makes adoption subsidies possible without regard to the income of the child's family of origin. Provisions regarding educational stability and health care coordination attempt to improve outcomes for children in foster care. This act also allows states to extend foster care placement for youth up to age 21 and enhances the funding available for independent housing or group care.

Child and Family Services Improvement and Innovation Act of 2011

The most recent of the legislative attempts to shape child welfare services, this act strengthens emphasis on children's well-being by requiring states to address the developmental needs of children in their case plans. It also authorizes the approval of multiple Title IV-E waiver demonstrations between fiscal years 2012 and 2014; the demonstrations will allow states to test innovations in practice, with a focus on improving children's well-being.

The Convention on Protection of Children and Cooperation in Respect of Intercountry Adoption and the Intercountry Adoption Act (The Hague Adoption Convention)

The Hague Adoption Convention was developed at the Hague Conference on Private International Law in 1993.[4] The intent was to regulate international adoption, protecting children by requiring that each country have a centralized system for administering international adoptions and a system for accrediting agencies, as well as requiring that consent to adoption be freely given and prohibiting improper financial or other gain. The convention was signed by the United States in 1994. The United States was slow in writing the regulations to implement the convention—they were published in 2006. The state locus of adoption law made implementation of some of the standardizing provisions difficult, as did the provision around accrediting agencies, given the prevalence of independent adoption in the United States.

The central system for administering international adoptions in the United States is the Office of Children's Issues, part of the Bureau of Consular Affairs at the U.S. Department of State. The Council on Accreditation (COA) is the accrediting agency for adoption agencies arranging and supervising international adoptions in the United States; many adoption agencies already have COA accreditation.[5] Immigration statistics enable us to monitor the numbers of international adoptions and the countries of origin of the children.

The Judicial Framework

The U.S. Supreme Court has, in a series of judicial decisions, established the balance between the rights and responsibilities of parents, the rights of children, and the interest of the state in protecting its future by protecting children from harm. There is a long tradition of parental control over decisions affecting their children, and many Supreme Court decisions have reinforced these parental rights. However, the court has also established that children have rights, though these rights may be limited by children's vulnerability and need for protection, and by immature cognitive processes, which impair decision making. Children's rights to protection from parental abuse, neglect, and exploitation were established in the nineteenth century, and the juvenile court still carries out this function.

In very general terms, Supreme Court interpretations of law have established that parents have the right to the care and custody of children and the responsibility to provide financial support, physical and emotional care, and guidance.[6] They must also see that the child has medical care and education. The courts have valued the diversity of family lives and have moved very cautiously to intervene in parental authority and privacy. Except in extreme cases, education and medical care have been two areas in which there have been court decisions affirming the rights of parents to make decisions that are in keeping with religious tenets, even when a larger society might think these decisions harmful.

The definition of family has been before the court in various cases for many years. Fathers never married to the children's mothers have gained some legal rights in recent decades, if they have had a consistent relationship with the children and have provided some financial support. The awarding of custody and permitting adoption by same-sex couples is increasingly common, though legal approaches vary according to state law on marriage. The question of what constitutes a family has often come before the courts in recent years. Does a family include grandparents, and do they have rights? In a disputed adoption, who is the child's family?[7] In a series of decisions, the Supreme Court has generally determined or has supported state courts in determining that biological parents have the right to raise their children without interference from the state until they are judged to be unfit.

In all of the decisions concerning the rights of parents and the rights of children, the courts are defining the extent to which the state may

use its police powers to intervene in family life. The responsibility of the state to provide for children, once custody has been assumed, has not been the subject of Supreme Court decisions. It has, however, been the basis of class action lawsuits in several states. These lawsuits represent attempts to reform the child welfare system through court judgments and through court-ordered funding of whatever reforms or obligations are decided upon. Decisions favorable to the plaintiffs in these cases lay the judicial groundwork for the assumption that the state has a responsibility to provide services to ensure the well-being of children in care.

In summary, parents are viewed as having the right to care for their children, to have their custody, and to make major decisions about their care. The courts have been hesitant in infringing on the rights of parents. Most decisions favor biological parents. The concept that children have rights independent of their parents has been affirmed by the courts and is expressed in the due process provisions of the juvenile court. The right of the state to use its police powers to intervene in family life when parents abuse, neglect, or exploit their children has been affirmed; the responsibility of the state once it has intervened is a less well-defined and continually evolving area of law.

Interface of Child Welfare with Other Public Systems

In this section, the interaction of the child welfare system with other systems is outlined. The justice system is a major player in decision making, protecting the rights of all involved. Other agencies supplement the resources of the child welfare system. Finally, stresses that have emerged in the child welfare system are identified and briefly discussed.

The Justice System

The courts are a major player in the child welfare system. Every step of the child welfare process is guided by the courts. We noted earlier in the chapter that judicial interpretation of legislation shapes policy. Courts monitor the safety and progress toward permanency of children in the child welfare system. Because families are often involuntary clients, the courts protect parental rights while balancing them with child safety. Only with juvenile court involvement can a child be removed from his or her parents for more than a brief emergency period, and only with juvenile court involvement can a child welfare case be closed. As the child's case moves through the system, juvenile courts provide oversight, determining whether reasonable efforts (or active efforts, in the case of tribal children) are being made to maintain family ties. Sometimes family or criminal courts are also involved in aspects of the case.

The interface of the criminal justice system, the juvenile court system, and the protective service system is not always easy. In decision making about handling of abusive and neglectful families, courts and social agencies do not always agree. Even when they may agree as to outcomes, agency and court procedures can be at odds as to the process of getting there, delaying the progress of a case or preventing its timely resolution.

Juvenile Court Involvement Juvenile courts handle two types of cases: those in which a juvenile has broken the law and those in which planning for a child is the issue. The court that hears these latter cases is usually called the dependency court.

A key aspect of the Adoption Assistance and Child Welfare Act of 1980 (Public Law 96-272) was the institution of increased supervision of the work of public agencies through periodic court reviews. This judicial oversight is typically provided by the state's dependency court system. The court may be assisted by citizen review boards, made up of community volunteers appointed by the court. The intent of court involvement is to promote timely decision making and to provide checks and balances for the work of the agency. However, the addition of multiple players and systems can add delays

unless all players understand one another's roles and learn how to collaborate well in the best interests of the child.

The child welfare agency and the courts are intertwined in the service of children. The professional cultures and practices of the two create an uneasy partnership. Clashes between the adversarial nature of legal decision making and the more holistic, systemic nature of social work practice can cause misunderstandings and delays. In the legal system, members of families (parents and children) and the agency designed to help the family all become "parties" who can be treated as "adversaries" in a legal proceeding. This can have the result of putting the players most likely to hold the keys to resolving the issue (the parent/family on the one hand, and the agency on the other) at odds, where collaboration and full and transparent sharing of information might produce a better outcome. It is important for child welfare workers to be prepared for effective practice in the evidence-based, adversarial procedure of the courtroom in addition to the more familiar collaborative processes of case management and service provisions.

In many jurisdictions there is a third player. Many began to feel that the child welfare agency, involved in remedial work with the parents, could not be trusted to champion the best interests of the child. Traditionally, the *guardian ad litem* or a public defender represented the child in court, but this office was often so overwhelmed that there was no opportunity to really know children and their situations. To ensure that there was one person looking only from the point of view of the child in a court proceeding, many state court systems established Court Appointed Special Advocate (CASA) programs, which assign a trained volunteer to many children in the dependency system. The CASA gets to know the child well and becomes acquainted with the parents and, if the child is in foster care, the foster parents and provides valuable information to the court.

The role of the agency social worker includes the responsibility to negotiate relationships with each of these systems effectively. To get the best outcome for children, the child welfare worker must develop collaborative skills such as the ability to present a case in court and to a team, the ability to understand a wide array of other systems, and the ability to negotiate. Sharing decision making is a major part of a child welfare social worker's job today.

The Children's Bureau, recognizing that refinement of these interagency processes would benefit children, sponsored the passage of the "Court Improvement Program" as part of the 1993 Omnibus Budget and Reconciliation Act. This program provided funding for multiyear initiatives designed to assess and strengthen dependency court processes called for in the Adoption Assistance and Child Welfare Act. Through Court Improvement Programs, some juvenile courts are investing in more training for judicial officers, others are streamlining court processes like the docketing of cases, and still others are developing community resources to help families.

In recognition that the adversarial process is not the best fit for all families, jurisdictions across the country are experimenting with alternative methods of dispute resolution for dependency cases. These include the use of mediation, pretrial conferences, family group decision making, and other forms of collaborative case planning. Some courts and agencies are also implementing methods to empower families to participate more effectively in the process, with introductory classes on how the dependency court works or the assignment of mentors, advocates, or "navigators" to explain and guide a parent or child through the system.

Involvement of Other Court Systems Adult criminal and family courts, as well as the delinquency side of juvenile court, also impact public child welfare. For example, many families are involved in the criminal justice system. Parents are incarcerated; children need care;

and parents need, somehow, to maintain bonds with their children. Perpetrators of child abuse are, inconsistently, subject to criminal prosecution. Family violence involves both the criminal justice and the child welfare systems. Custody issues can be settled in family court. Adolescents in the child welfare system (dependency court) may also come to the attention of the delinquency side of juvenile court.

Criminal courts are involved if a crime such as child endangerment or child sexual abuse is alleged. In these cases, a defense attorney may advise the parent not to admit guilt and not to participate in services such as substance abuse treatment or sex abuse counseling that might imply guilt prior to resolution of the criminal case. This delays permanence for children. Some states are addressing these delays by improving coordination between the criminal and dependency courts in matters of scheduling or by prioritizing child welfare cases on the docket in criminal court.

Parents may be involved in family court in matters connected or unconnected to the dependency. Domestic violence, while posing dangers to children, will be addressed by law enforcement and family court and may or may not come to the attention of the dependency court. Parents incarcerated for crimes not related to their parental capacity present a particular challenge to the timely resolution of child welfare cases. How long should a child wait for the chance to be raised by an incarcerated parent? Can attachments be maintained while the parent fulfills a long sentence? Can good parenting skills be acquired or demonstrated by a parent behind bars?

Some jurisdictions are addressing this problem of multiple court systems by the introduction of unified family courts where all matters affecting a family may be seen by the same judge, and where a family may have access to a case management system that can coordinate hearings on the same day. Other jurisdictions are establishing family drug courts or mental health courts, where a parent receives more intensive and more frequent legal attention and support focused on these issues and their impact on the family system. Collaborative case planning across adult criminal and juvenile courts is also possible (though more in evidence in smaller court systems).[8] The National Council of Juvenile and Family Court Judges has established a model court program to assist juvenile courts in structural changes to reach better and more timely outcomes for children and families.

Other Systems

Multiple systems beyond the courts impact the families who are involved with the child welfare system. Many children are involved in Head Start or other early childhood education programs; almost all children are involved in the public school system.[9] The medical system is, of course, important for all families. These systems are, at least in their broad outlines, known to most of us. The mental health and developmental disability services systems are less familiar. Child welfare workers will work with many children with varying degrees of developmental disability and with children who have serious emotional disturbance. Because these children have particular needs, and because early recognition of their problems and early intervention is important, child welfare workers need to be familiar with the systems that serve these children. They must also understand the range of treatment programs and funding streams that can help parents address the problems they face in raising their children safely.

Developmental Disabilities Developmental disabilities have been defined in federal legislation concerning Supplemental Security Income (SSI) assistance in terms of the limits to functioning they present. Children are eligible if they have disabilities that would prevent an adult from working (Pecora et al. 2009:104). Though earlier assistance was limited to certain categories of disability, principally mental retardation, a 1990 Supreme Court decision

mandated the use of a more functional definition of disability. Developmental disability was then defined as a severe, chronic condition that is caused by mental or physical impairment and makes self-care, language, learning, mobility, and/or self-direction difficult.

Children with serious developmental disabilities were once routinely institutionalized, in the belief that they would fare better among others of similar capacity. The evidence is clear, however, that children cared for in families achieve better developmental outcomes, and the focus of services has shifted to the provision of support services to enable families to care for their children at home. These support services can be extensive, including arrangements for schooling, transportation, and the provision of foster homes for adults with disabilities.

Developmental disabilities can be both a contributor to and a result of child abuse and neglect. Children perceived as different or who are demanding are at higher risk for maltreatment. In addition, the extraordinary demands for special care that some of these children present can result in neglect when parents simply cannot manage to meet these demands. Physical abuse involving, for example, head injury or shaking, can be a cause of serious developmental disability. Neglect can have lifelong impact on child development. Recent research, reviewed in chapter 1, demonstrates that both neglect and abuse of young children distort normal brain development, leading to severe behavioral disorders.[10] Drug or alcohol use by pregnant women can result in damage to the fetus, and some child welfare systems automatically treat babies born with drugs in their systems as abused children. Once a child comes into care, the child welfare worker will need to find the appropriate services to support child development.

Children's Mental Health Child welfare workers will meet many children with serious emotional disturbance or other symptoms of trauma. The evidence is fairly clear that both severity and frequency of maltreatment and the developmental stage of the child are associated with later emotional or behavioral disturbance. NSCAW found that 41.4 percent of the children entering the child welfare system were in need of services for emotional or behavioral problems (Dolan et al. 2012). Greeson et al. (2011) estimate that 70 percent of the children placed in foster care have suffered complex trauma.

Additionally, some children, particularly adolescents, come into out-of-home care in the child welfare system specifically because of serious emotional disturbance. Some of these children are unable to function in a family setting and need the structure and intensive therapeutic intervention of a residential setting. Others may do well in therapeutic foster homes. For the families of these children, the cost of these treatment programs presents a serious obstacle. In many states, the state takes custody of these children, often labeling them "neglected," because there is no programmatic pathway to meet the costs of out-of-home care. This procedure creates unnecessary hardship for the family and an unnecessary obstacle in the eventual reunification of the youngster with the family. It is a good example of the failure of two service systems to coordinate their procedures. In other jurisdictions, innovative collaborative solutions have been developed involving braided funding streams, oversight, and support for families or using a wraparound approach to keeping children and families safe at home.

Managed Care

Managed care is essentially a strategy of organizing care to control costs while providing the entire range of services needed by a child and family. Having originated in the medical world, it depends on the ability to diagnose precisely, specify a known average length and type of care to match the diagnosis, and measure outcome. For a long time, it seemed that the managed care approach would not come to the world of child welfare, where this level of specificity is not possible.

However, managed care has indeed emerged in child welfare. Most prominently, it is used in Medicaid-funded treatment for disabilities, mental health problems, and physical illness. Nearly 90 percent of children entering foster care have physical health problems, one quarter have three or more chronic conditions, and nearly half have significant emotional and behavioral health conditions. As of 2012, thirty states were providing physical and behavioral health services to children in the child welfare system through Medicaid-managed care models (Allen, Pires, and Mahadevan 2012). These numbers will expand when Affordable Care Act coverage is extended to former foster children up to age 26 in 2014. Given the high level of need of children entering foster care, Medicaid is poised to become a major funder of managed care in child welfare.

Except in its use for health services, managed care has advanced slowly in child welfare. The discussion of the delivery of foster care services earlier in the chapter is one example. The models vary widely in size, focus, methods of organizing services, and risk sharing. The most commonly contracted services are out-of-home care, though some states have initiatives focusing on family preservation and in-home support services.

States have developed these managed care initiatives to fit the particular needs of their systems, with goal of providing a full array of services for all children. Some are contracts with a single provider—almost always a not-for-profit provider. Some use a lead provider model. Lead provider contracts stimulate the development of service delivery networks, as a lead agency takes on the case management and subcontracts with an array of providers to obtain needed services. Risk sharing is common (McCullough and Schmitt 1999:39).

Given current popular distrust of government and the perception that the private sector delivers more cost-effective services, the movement toward increased sharing of case management and service delivery between the private and public sectors will doubtless continue.[11] Public-private partnerships also bring to the table agencies that possess particular linguistic or cultural expertise and can leverage philanthropic support and volunteer resources often unavailable to a public agency. For all these reasons, the public agency is entering into an environment of shared responsibility. However, the public agency continues to retain legal authority for most child welfare cases and is held liable both in the courts and in the court of public opinion if anything goes wrong with a case.

Whether this privatization and managed care initiative is good for children is open to question. An early controlled study of the impact of managed care found that children in managed care were receiving fewer services and that they were no more likely to move quickly through the system than children receiving "regular" foster care (Meezan and McBeath 2003). Troubling stories are reported of providers spending relatively little on direct services to children and diverting funds into administrative costs or profits,[12] but troubling stories are also reported of poor services to children delivered directly by the public child welfare system. Carefully crafted studies with control groups and reporting of issues and outcomes will be important.

As appealing as it may be, any change in the current structure, such as the introduction of managed care, should be entered into with a great deal of attention to avoiding the interruption of services to children and families. Effective systems for monitoring the process of service delivery are needed in both the private and public sectors, for children are very vulnerable. The monitoring of process should not be lost in the current interest in outcomes. In this regard, the CFSR process will be important.

Child Welfare Services Under Stress

This chapter has documented the growth over the past century of a complex system of government and private entities, decision-making processes, and funding streams, all of which must come together to support the best outcome for

abused or neglected children. This system is now under stress in a number of ways.

Protective Services

During the 1970s, states developed laws that mandated reporting of child abuse and broadened the definition of reportable abuse. Television and newspaper publicity informed the public of the existence of abuse and how to recognize it, emphasizing the responsibility of every citizen to report child abuse and neglect. These campaigns also stressed that reporters could remain anonymous and would be immune from prosecution for libel. The response was overwhelming. In 1976, there were 416,000 reports, by 1985 almost 2 million (Kadushin and Martin 1988:244). In 2011, there were 3.4 million reports of maltreatment made to protective service agencies (U.S. Department of Health and Human Services 2012a).

This vast increase in the number of reports to be investigated and numbers of families and children who were identified as needing services—in the absence of corresponding increases in funds—challenged the capacity of child protection agencies. Reports were so numerous that it was not possible to investigate them all or to investigate quickly. The failure of child protection agencies to respond to the reports of other professionals created strains within the system of cooperating agencies. Failure to respond to citizen reports created serious public relations difficulties. Failure to respond when a child died created public outcry.

> Responding to calls from doctors, police, teachers, and grandparents who believe a child has been mistreated, caseworkers knock on doors, ask personal questions, look inside refrigerators, and check children's bodies for bruises and burn marks. They have the power to take children temporally from their homes and parents, if the risk of harm appears severe. They also have the discretion to determine that nothing serious happened or that it is safe for the child to remain home while the parents are urged to change. The stakes are high. Overestimating the degree of danger could needlessly shatter a family and rupture the child's closest relationships. Underestimating the danger could mean suffering or even death. The decisions caseworkers make every day would challenge King Solomon, yet most of them lack Solomon's wisdom, few enjoy his credibility with the public, and none command his resources. (Larner, Stevenson, and Behrman 1998:4)

Public child welfare agencies are struggling with an environment of increased workload pressure, limited funding, and a watchful community critical of their performance. Community standards for caregiving are rising at the same time that family structure is changing and communities seem to be offering less support to families. The great increase in referrals for protective service investigation is one factor in this increased workload. Another factor is the increasing complexity of the family problems presented to child welfare agencies, such as substance abuse or addiction, necessitating longer and more intensive work with families and often resulting in foster care placements and the need for intensive work with children and foster parents. Foster care is also in crisis, with the number of available homes declining at the same time that the number and severity of need of children requiring placement is rising. Child welfare workers need training, supervision, and an organization that will support them in difficult decision making and service delivery. Funding has not increased sufficiently to provide needed resources. And the public is increasingly aware of deficiencies in meeting the needs of children, and critical of performance.

Public agencies can control their intake only through definition of the populations they will serve; they cannot, as a private agency can, say they have "no room" for new cases. The pressure of large workloads is placed on public agencies by the broad definition of maltreatment that brings cases to them and by their mandate to serve all children who need protection. Some

states have narrowed their definitions of maltreatment so that intervention in family life is warranted only when there has been demonstrated harm to the child or when families can be identified as "high risk." However, we do not know at what point minimally adequate care escalates into neglect or abuse. We do know that early intervention can sometimes prevent more serious problems.

In many jurisdictions, there is no existing network of private agencies with capacity sufficient to serve "low risk" families who need help. Working with "low risk" families early on to prevent more serious problems is widely acknowledged as best practice. However, federal funding is limited for these family support/family preservation programs, and already strapped state budgets can rarely accommodate bringing this part of the system up to full capacity. Some IV-E waiver demonstration programs are taking on this conundrum, providing research on early intervention efforts for child welfare eligible families.

Foster Care

The main point of entry of children into foster care is through the protective service system. For children who need placement, the ideal approach is that the worker select a home, preferably that of a relative, prepared to handle the issues of the particular child, geographically close so that parents can visit, comfortable in terms of language or culture, and with few enough children in it that it can attend to the needs of the newcomer.

Unfortunately, the child welfare worker rarely has the opportunity to choose with such care. Changing demographics—particularly an increase in the number of single-parent homes and the entry of women into the workforce—coupled with low reimbursement rates and limited recognition has resulted in a steadily declining number of available foster homes. Often, foster children are adopted by their foster parents, further contributing to the attrition of foster homes, and at the same time underscoring the importance of choosing the original placement with care.

Public criticism of foster care often focuses on the many moves that some children make. This is more extensively discussed in chapter 6. It is sufficient to note here that a shortage of foster homes can lead to use of a foster home that is not well suited to meet the needs of a particular child. Inappropriate placements can lead to moves. Each move further traumatizes the child. A review of studies of long-term foster care reveals an amazing amount of movement among children in foster care, with a repeating pattern of some children experiencing relative stability, and some children having multiple placements. The foster care system is subject to almost as much criticism as the child protection system.

The systemic response to this issue has been to attempt to decrease dependence on foster care. At its best, this is done by keeping children in their own homes through intensive services to the family or, when there has been a placement, moving children back home or into adoptive homes as quickly as possible. Policy initiatives leading to increased work with families to try to prevent moving children and placement of children with relatives have decreased agency reliance on nonrelative foster homes. These are the tenets of family preservation and permanency planning and are good policy. However, the need for foster homes remains.

Recruitment, Training, and Retention of Qualified Staff

Across the child welfare system, staff recruitment, training, and retention are issues of concern, but the problem is nowhere so pressing as in the child welfare agency. The investigation of each child maltreatment complaint and the assessment of the risks to the child and of the family's capacities demand a high level of clinical skill. The complexity of the problems faced by the families and the children necessitate similar levels of skill in the provision of direct service or the arrangement and supervision of

services from a variety of other agencies. Each case requires difficult decisions that may have grave impact on the life of a child.

There is a surprising lack of empirical work documenting the characteristics, educational background, and training needed to do this work. Social work has long been allied with child welfare, and many think that the philosophy and skills taught a social worker are effective in child welfare work. Most child welfare agencies provide in-service training to build on the educational background of their employees, though in times of budgetary difficulties training is too often sacrificed to maintain direct services. However, it does little good to recruit staff with proper background, train them to do the work of the specific agency, and then have them leave. Retention is a key strategy to ensuring a workforce that is a match to the demands of the work.

Staff turnover in child welfare is the critical issue explored in the last chapter of this book. At this point, it is sufficient to note that turnover commonly exceeds 30 percent (Nissly, MorBaarak, and Levin 2005). Staff turnover leaves vacancies, starting the costly cycle of recruitment and training again. This repetition of recruitment and training consumes needed agency resources, and it wastes the experience and practice wisdom of the workers who have left. Vacancies cause caseloads to rise for remaining personnel, increasing the risk to children. Work with families and the relationship with a child or youth is disrupted and decision making delayed. It is vital, therefore, to discover the reasons for turnover and to put the support structure in place that will maximize work satisfaction and desire to remain in the agency.

Systems Working Together

It is clear from the discussion in this chapter that child welfare is not one agency or profession; it is a complex, interlocking network of agencies and professionals that includes other systems such as courts, health and treatment providers, and education. This means that the fate of children and families is shaped by the policies, program constraints, and professional cultures of very different worlds. Effective advocacy for children requires that a social worker be informed about and alert to the opportunities and constraints presented by colleagues from other disciplines. It requires coordinated interdisciplinary work at the level of work with the individual and at the level of understanding and accessing the many systems that impact families.

Interdisciplinary Work

The historically separate development of the many systems serving children and families has created differing value systems, different languages, differing decision processes, and distinct sets of laws and regulations, all of which tend to separate systems. These are obstacles that need to be overcome for effective interdisciplinary work.

For example, legal professionals and social workers often seem at odds, due to differing professional cultures and ethical obligations inculcated from the very first day of their professional training. A law student is taught to argue, to defend a point of view, to operate only from facts in evidence, and not from subjective information. The law student learns an ethical obligation zealously to defend the client's stated position, regardless of personal opinion. By contrast, the social work student is taught to look at a situation holistically and to seek solutions that will best meet the needs of all players, staying away from an adversarial posture. This can make it hard to collaborate to seek solutions.

Confidentiality standards can challenge interdisciplinary work. For example, under the Health Insurance Portability and Accountability Act (HIPAA), health and drug treatment professionals and therapists have a very high threshold of confidentiality. Similarly, the Family Educational Rights and Privacy Act (FERPA) limits the sharing of information

between schools and foster care. This can seem frustrating to child welfare agency workers who feel that this information is necessary for decision making. Clear contracting and requests for information in accordance with federal confidentiality standards, releases of information designed to meet the needs of multiple agencies, and involvement of the client in decision making are all approaches to managing these dilemmas with integrity.

The connection between law enforcement and child welfare is vital to child (and worker) safety and good outcomes. Law enforcement officers may accompany child welfare workers on a home visit likely to end up in a removal, and sometimes may remove children on their own. The training law enforcement officers receive in maintaining safety and in gathering criminal evidence is invaluable in the child welfare process. The legal authority of a police officer is a vital part of many child welfare interventions. Clear interagency protocols and ongoing structures for communication and problem solving can result in powerful partnerships between law enforcement and child welfare social workers for the benefit of children. Around the country, strong working agreements between law enforcement and child welfare have improved outcomes with children endangered by domestic violence or drug-endangered children.

Many referrals to child protective services come from schools. Although they are mandated reporters, many educators are not familiar with the boundaries and mission of the child welfare agency. Without this context, educators may consider the narrowly defined intake criteria a sign of lack of responsiveness or lack of caring on the part of the child welfare agency. Cross-training sessions to explain child welfare agency constraints, intake criteria, and to illuminate how to refer a case can help this situation. Conversely, child welfare social workers need to work closely with schools to help children succeed. A child who has been abused or neglected can present behaviors that make it hard to manage a classroom. Communication about the special health and behavioral supports a child will need to succeed and mechanisms to negotiate funding for these supports are characteristic parts of a system that works well.

Differing Perspectives, Differing Aims

Throughout this chapter, child welfare has been discussed as a system of interlocking players as if child safety, permanence, and well-being were the primary focus for all participants. This is not always true. Some partners whose services are essential for the well-being of the child do not necessarily hold this as their central concern. For example, in the earlier discussion of family violence, we noted that a primary difficulty in coordinated work was the desire of a woman's service organization to protect the mother from further victimization, such as the trauma of having her children removed. Similarly, a drug treatment provider will have the recovery of the parent as the primary concern and may advocate for a long time-frame in which the parent is relieved of the stress of parenting. In both cases, the parent is their client, not the child. It is not that these organizations are careless or heedless of the child's issues; in fact, they often raise critical concerns about child safety and have information about relapse to offer. But the parent's issues come first. Frustrations and problems will arise unless each participating agency clearly understands the role played by each other agency and respects its commitment to its primary client.

Communication and coordinating mechanisms and interagency protocols can then be developed that take these differing perspectives into account. A key concept may be agency flexibility. As any service matures, a flexibility of response attuned to the situation presented develops. Thus, we are beginning to see child welfare modifying its traditional investigative approach to all families and working to engage families in voluntary services through an alternative response to reports of maltreatment that appear to be low risk.

Similarly, the new focus on permanency within a short time-frame as a preferred outcome for all families may not always be the best practice; when neglect is related to substance abuse, it may be that for some families the ultimate goal of family reunification is more important than a short timeline to the reunification. Placement with kin can realize the twin goals of having children remain in the family system, while allowing the parent time to work on recovery. Or treatment providers can develop more flexibility in programming; some have found a way to accept mothers and their babies together, finding it increases early motivation for recovery and allows for uninterrupted child attachment. The examples could be continued. The implementation of such ideas will, of course, demand imaginative caseworkers and community partners determined to think creatively, advocate for the best for their clients, negotiate support from agency management, and consider entering the policy arena. Innovation and flexibility in one system often sparks a similar response in another system. And the social worker's skill in building relationships is an asset in developing cross-systems collaboration.

Funding for Services

Categorical funding streams—different agencies having different sources of funds—are one of the biggest challenges to the smooth functioning of the vast interagency system this chapter has described. It can take years to develop an understanding of the various funding streams of each of the interagency players. Developing this "systems savvy" will make a child welfare social worker or advocate more effective.

From the mental health field comes the concept of "wraparound services" or "system of care," which propose that services be customized to and driven by the needs of a child, adult, or family rather than by the shape of the service delivery system. These approaches typically use family-led interdisciplinary meetings, draw on informal as well as professional supports, and recognize the strengths and culture of a family as well as its needs. This useful conceptualization has been taken up by child welfare, and its implementation demands coordination at the systems level. Most public child welfare agencies do not, however, provide funds that will enable the purchase of services from other agencies on a case-by-case basis. Managed care, discussed in the preceding paragraphs, is one way to procure these services. Another approach is to provide flexible funds that can be accessed by the worker to meet particular needs; this has shown great promise in jurisdictions using a system-of-care approach.

Another fundamental service delivery problem is the need for flexibility. Because they are large public bureaucracies engaged in a high-stakes enterprise, child welfare agencies tend to prefer a uniform approach to all cases, prescribing specific procedures that must be followed in each case rather than encouraging a customized approach that takes into account the fact that families coming to the attention of child welfare are a varied group whose needs change over time. Bureaucratic procedures exist to be sure that services are delivered in a fair and equitable way. However, these procedures can get in the way of individualizing services to meet varied needs. One size does not fit all. Developing flexible funding options or using funds from one player as a match to leverage increased funding from another are strategies that have brought greater integration and the experience of a more seamless "system" for children and families.

Responsibility to Those Served

All social service systems are, of course, ultimately responsible to those they serve. It is easier to lose this sense of responsibility in child welfare than in some other systems or to lose sight of who the client is. Public child welfare employees are public servants and serve the public by protecting children. The children served are most often poor, young, and have relatively little power. Judicial and public oversight—formally through the legislature and

also through the media and other expressions of public opinion—can help to keep the system responsive. But sometimes judicial or public pressure is at odds with family or cultural views. Social justice issues constantly arise in the interplay of these competing or collaborative players. The following discussion summarizes the various accountability and oversight mechanisms at play in child welfare.

Agencies that have the authority to intervene in family life, insist on lifestyle changes, and if necessary remove children inspire fear. These same agencies have the responsibility of providing services or organizing the network of community service providers so that families are enabled to take better care of their children. Partly because of the immense power and responsibility entrusted to these agencies, external oversight is important. The formal channels for public agency oversight are in the federal funding system, the courts, and the legislature. The media and other advocacy voices also provide informal review of agency functioning.

Formal Oversight

When the federal government spends its funds on child welfare services in the states, it wants to know how those funds have been spent and wants assurance that federal standards for services have been met. The reporting requirement thus acts as a system of oversight. An unintended consequence of the system is, of course, the enormous burden of paperwork it entails, which increases workload pressure on the service-providing agencies.

The Child and Family Services Review, described earlier in the chapter, is an attempt to build a partnership between the federal government and state child welfare agencies to promote common understanding of clear child welfare outcomes and elements of a high-quality systemic capacity. The program improvement plans and incentives are designed to shape child welfare systems while allowing individual variation and innovation from state to state.

The oversight role of the court and of court-sponsored programs such as CASA and citizen review boards was described earlier in this chapter. In addition to the court, other bodies provide oversight, or checks and balances to the system. Interdisciplinary child protection teams that review child protection decisions are in place in many states. Some states have set up placement oversight panels for Native American children, providing cultural expertise and a connection to the tribes for Native American children who come into care. Although the forms vary, these case-level oversight and planning mechanisms are now an integral part of the child welfare system in every state.

Case-level oversight is not always welcome; busy caseworkers often see the demand for review as an indication that their decision making and casework are not trusted. To get the best results for children, a social worker must be skilled at presenting a case to a team, distilling the case facts to clear points, and identifying the key practice issues for discussion. In this way, the social worker can engage the team or review board as a partner in planning for children.

Informal Oversight and Accountability

The news media are an influential, though informal, review system for public child welfare agencies. Media coverage may elevate public outrage about a case in which a complaint of maltreatment has been made and investigated, and a child left with a family, only to be seriously harmed. Equally common are stories of the removal of children from a home over the protests of the parents, sparking public outrage over unfair government interference. Such publicity can have a demoralizing effect on workers inside the agency, who worry that one of their cases could be the next headline. However, such media coverage can work to the advantage of the system as well. In the hands of a skilled administrator, a well-placed story or a powerful positive statement that leverages the awareness raised by the media coverage can secure the political momentum for desired

policy or practice changes and can leverage increased public funds through increased public understanding.

The media do more than monitor child protection through highlighting difficult decision making. There are also frequent pieces on the system as a whole—the workload pressures of the protective service worker, the difficulties of the child in foster care, the problems families have in accessing services. Thus, the community is kept informed about the health of its child protective system. An agency that can manage to maintain a regular flow of such "good news" stories can build a reservoir of good will to draw on when the "bad news" hits.

Because the state has the authority to remove children and to decide where to place them, it at times creates situations in which parents, relatives, or the young people themselves feel they have been unjustly treated. Some states have established child advocacy or ombudsman's offices, usually reporting directly to the governor, to provide a place for grievances to be aired and to offer checks and balances to over- or underzealous child welfare work or failures of the larger system. Some citizen review programs operate primarily at this systems oversight level.

Advocacy organizations are an important part of the accountability system. Groups formed by grandparents and/or parents have grown up in several states to lobby for the rights of relatives to be represented in court, to have children placed with them, and to visit when this is not possible. Foster parents have organized, on both state and national levels, to insist on recognition of their roles, fairness of compensation, and standing in court. There are now several major national organizations of current and former foster children that create opportunities for those in foster care to communicate with each other and are highly effective advocates for systems change.[13] These organizations keep the public informed and can be valuable external allies to systems change efforts.

An important movement in child welfare is the proactive involvement of family voice and youth voice at all levels of decision making from individual case planning up to the highest reaches of policy making and oversight. While in previous decades families had to take a very angry and adversarial stance to be heard, it is now much more common for families to be included in planning both at the case and policy levels. Family group decision meetings and related structures to include families in planning are present in many jurisdictions providing important structures to include caregiving parents and extended family in planning for children in care.

The stakes are very high, and decision making in child welfare is not fail-safe; the more input that can be gathered, the better the odds of getting a good outcome. Often, family members have information, resources, and an unconditional commitment to children that far surpasses what can be provided when only professionals are involved in decision making. The ability to participate in and facilitate such meetings is becoming a core skill set for success in child welfare.[14]

A national network of family voice and leadership organizations is being formed to mobilize best practices around parent leadership.[15] Parent mentors, parent organizations, and parent advocates are becoming more common in child welfare, following the parallel model of the National Federation of Families for Children's Mental Health, which gives voice to the perspective of parents of children in the children's mental health system.[16]

These informal advocacy systems, including the growing voice of families themselves, are important in shaping the system. Even though complex and multilayered, the public child welfare system must respond to community demands and be accountable to the public.

Critical Issue: Building Lifelong Family Connections

Since 1980, a cornerstone of the policy framework within which child welfare services are delivered has been planning so that by the end

of services each child has a permanent home. The new Family Connections Act builds on this cornerstone to emphasize that this work begins the first day of a case and continues through until the child's case is closed by the court. Along with child safety and well-being, permanency planning is an organizing principle of child welfare, and the achievement of permanency for children is a major outcome measurement. It means, simply, consistent planning so that each child achieves a home that will provide lifelong safety, nurture, and belonging.

Permanency planning begins with the decision about whether a child should enter foster care and with the attempt to support the child's current home so that a move can be avoided. If a child must enter foster care, in order to minimize trauma the preference is placement with a relative known to the child. The goal is as few moves as possible, so making the first placement the right placement is very important. If the next move can be back to the child's original home, that is the preferred option. If this is not possible, the second preferred option is termination of parental rights and formal adoption, by a member of extended family if that is appropriate or, if not, by his current foster family or a home newly recruited. It should be noted that formal termination of parental rights and formal adoption is not the preferred first option in many tribal court systems where other legal mechanisms are used to ensure lifelong connections. Guardianship by a relative or long-term foster parent is a third option. All of these plans secure for the child a home where the emotional connection and intent to care is lifelong and where that intent is backed by the sanctions of a legally established parent-child relationship.

A permanent home for a child should be secured without undue delay. ASFA mandates that planning for an alternative permanent home begin as soon as a child enters foster care and has created a limit on the time children can spend in foster care without action being taken to move them into a permanent home. If the hope is to move children back to the permanency of their original homes, this can create difficulties when parents have problems that are not quickly resolved. Drug and alcohol addiction are among the most common of these problems as parental recovery can take longer than the fifteen months required in ASFA.

The Theoretical Base of Permanency Planning

The emphasis on permanency began with the recognition that without a continuing interaction with a consistent caretaker, children did not develop well. In 1951, Bowlby drew together the findings of other observers in a monograph that, by demonstrating the devastating physical and developmental consequences for children raised in institutional settings without the interaction of maternal care, changed the then-current thinking about care of infants and very young children (Bowlby 1951). In those days, foster care, where the child was able to form an attachment to a consistent caretaker and had the stimulation of family living, became the preferred mode of caring for young children. In fairly rapid succession, other observers documented and reported the depression of young children separated from parents, foster parents, or other long-term caretakers, noting a sequence of anger, depression, and finally apathy, in which normal development ceased (Robertson 1958). Though it soon became evident that the effects of separation were being confounded with the effects of the sensory deprivation of an institutional setting, this work had the important effect of bringing out the damage to young children that separation from family could cause.

This body of literature, expanded and reinforced through the years, has formed the theoretical base for the emphasis on permanency for children. Fahlberg writes of problems in attachment being manifested in psychological or behavioral problems, cognitive problems, and developmental delays (Fahlberg 1991). A traumatic relationship, such as the relationship of a child and a severely abusive parent, may make

the child afraid to risk another attachment. Interrupted relationships, which make the child reluctant to trust, create another type of attachment problem; Ner Littner, in a theoretical monograph based on his clinical observations, documented the destruction of a child's ability to trust and to form new attachments if old attachments were repeatedly disrupted (Littner 1950). This is the type of attachment problem that grows from repeated moves in foster care. Finally, attachment problems can come from profound neglect that deprives the infant of the opportunity to make a primary attachment; these are the difficulties found in infants that were cared for in poorly staffed orphanages.

A key to this theoretical base is the determination of who is the child's "real" family. When a child spends a long time with any family, including one that is not the original biological family, attachment bonds form. The concept of the "time clock of the child" is important here; two or three years is a long time in the life of a young child—a large proportion of his or her life (Goldstein, Freud, and Solnit 1973). The bonds that form may be so strong that this family becomes the child's psychological family, so that the child's developing attachment and sense of security would be well-served by remaining there.

The Empirical Base of Permanency Planning

For more than forty years, there has been evidence that too many children placed in foster care tended to "drift," without planning for more permanent homes, in foster care. "Foster care drift" became a major concern of the critics of the child welfare system and of the system itself. These children formed attachments to their foster families. But foster care is subject to the stresses and changes of life, and often children were moved from one home to another. Each of these broken attachments was damaging.

In 1959, Maas and Engler produced a careful, national study, revealing that more than half of the children placed in foster care would not return to their own homes; indeed, children who had been in foster care for eighteen months were likely to remain more or less permanently in out-of-home care with all the possible uncertainties that implies (Maas and Engler 1959). Almost twenty years later, a series of studies demonstrated that children were, indeed, still drifting without planning for long periods of time in foster care (Fanshel and Shinn 1978; Gruber 1978; Knitzer, Allen, and McGowan 1978). Again the alarm was raised.

In the early 1980s, it seemed that the concern about finding permanent homes for children had mobilized the child welfare community and that large numbers of children were moving out of foster care, back home, or into adoptive homes. A series of studies demonstrated that even parents who had lost touch with children in a foster home often were interested in having them return home and that adoptive homes could be found for other children (Hargrave, Shireman, and Connors 1975; Emlen et al. 1978; Jones, Neuman, and Shyne 1976). The idea of adoption changed, with older children who needed homes now classified as adoptable. Excitement was generated among child welfare workers by the many publications from innovative agencies demonstrating their ability to find adoptive homes for increasingly difficult children.[17] Children with disabilities, older children, children with behavior problems—adoptive families could be found for most. (Age proved to be the greatest obstacle to adoption; adoption of adolescents was particularly difficult to secure.) The number of children estimated to be in foster care in the United States fell from 400,000 in 1977 to approximately 276,000 in 1984 (Kadushin and Martin 1988:355). It was predicted that by the 1990s, the foster care population would be young children who needed very short care during a family crisis and adolescents who would grow up in stable foster homes in which, often, they had lived for many years.

Unfortunately, however, the earlier predicted reduction in the use of foster care yielded to a

tide of family difficulties. Concurrently with the rise in the use of crack cocaine in the inner cities, followed by other drugs such as methamphetamines, which had devastating impact on families, and concurrently with the divergence in income distribution in the United States, with the poor growing ever poorer, the number of children entering foster care began to grow again. By 1998, there were 600,000 children in out-of-home care in the United States.

Legislative Response to Increased Use of Foster Care

In 1980, the Adoption Assistance and Child Welfare Act was passed. Prominent among its provisions was the requirement that a permanency plan be established for each child and the mandating of periodic reviews of children in foster care to see that they were progressing according to the goals of the plan. This prevented children being placed in foster care and left to "drift" in the foster home. Fifteen years of experience with the law demonstrated the soundness of the policy framework, but numbers of children in foster care continued to rise, as did the length of time children were in foster care.

In response, the Adoption and Safe Families Act of 1997 followed. ASFA, with its mandated short timelines between placement in foster care and placement in a permanent home, has been a particularly strong impetus toward movement of children out of foster care and into permanent homes. The Family Connections Act of 2008 has provided new legal frameworks and support for securing permanence with kin. Many practice and systems innovations across the nation appear to be turning the tide and reducing out-of-home placement.

Substance Abuse—An Obstacle in Permanency Planning

The reasons that children are removed from their homes are multiple, and many are not easily resolved. Prominent among the reasons that children are removed from their homes are issues stemming from parental substance abuse, involved in almost two thirds of situations in which children are placed in foster care (Dolan and Smith 2012). Substance use is a major issue in the community. Every year the Substance Abuse and Mental Health Services Administration (SAMHSA) conducts a survey to determine the incidence of drug, alcohol, and tobacco use. The 2011 survey results indicate that use of drugs is increasing, with use of marijuana being responsible for most of the increase; use of alcohol remains constant; and use of tobacco products is showing a slight decrease. More than 8.3 million children lived with at least one parent who was dependent on or abused alcohol or another drug (Substance Abuse and Mental Health Services Administration 2011).

The Adoption and Safe Families Act, with its short timelines for parental action to make their home safe for their children, introduced a dilemma for child welfare. While return to the original parents or caretakers remains the preferred outcome for children taken into out-of-home care, recovery within the timeline is often not possible.

The Nature of Substance Abuse In thinking about the impact of the use of alcohol and/or other drugs on family life, it is useful to begin by recognizing that use occurs on a continuum. At a common and familiar end is the low or infrequent use of substances with few and rare negative consequences. Many children grow up in homes in which parents use alcohol or drugs and there is not a sufficient safety threat for them to come into child welfare.

Substance abuse, in contrast, is a pattern of substance use that leads to significant impairment in, among other things, fulfilling the responsibilities of family life. Substance dependence or addiction is the progressive need for alcohol or drugs that results from use of that substance; physical dependence occurs when the body adapts to the substance and needs increasing amounts to maintain psychological

functioning and ward off uncomfortable effects of withdrawal. Addiction is thought of as a chronic disease, and successful treatment requires a change of habits and lifetime management. Lapses (substance use after a period of abstinence) and relapses (use of substances again and return to associated problem behaviors) are common (ICF International 2009). It is sometimes difficult for child welfare workers and courts to distinguish between substance use, substance abuse, and addiction. These are important distinctions in tailoring expectations.

Poverty, homelessness, domestic violence, mental illness, and crime frequently co-occur with substance use disorders—these are, of course, the set of factors that often co-occur with child abuse and neglect. It is at times difficult to distinguish the impact of the substance use disorder and the impact of the co-occurring factors. For example, the substance abuse may be secondary to—even as a way of self-medicating—an underlying depression or other mental illness. And in planning for child safety, this entire set of difficulties needs to be resolved.

Substance use disorder, as a chronic disease, is treatable, as are other chronic diseases. Treatment must occur under the guidance of a substance use disorder treatment agency that will assess the particular characteristics of the client's disorder, prescribe the treatment best suited to it, and support the client through the treatment.

Substance Abuse Treatment and Child Welfare In working with families in which substance abuse is a problem, the child welfare worker must work in partnership with the treatment agency. Though these two agencies have a common goal of parental recovery (in the child welfare system's view so that the child can return), there may be pressures that make continued focus on that goal difficult. The two systems differ in fundamental ways. Parents enter substance abuse treatment when they are ready and leave when they wish, while involvement with the child welfare system is often involuntary, and the consequences of failing to change can be loss of their children. Workers have different training. Both systems have strict confidentiality rules, and the sharing of information in a way that will assist the family can be problematic.

A major difference in the two systems is differing timelines. ASFA mandates that a parent be able safely to care for a child within approximately a fifteen-month framework, necessitating rapid resolution of the problems that brought the family into protective services. Substance use treatment providers know that there may be lapses from abstinence as part of the recovery process.

Child welfare workers will need to establish collaborative relationships with substance abuse treatment providers. Establishing collaborative relationships requires experience working together, respect for the expertise of each field, and the building of trust. The network of relationships grows over time as systems interact, and common solutions can emerge. For example, many jurisdictions now have residential substance abuse treatment facilities where parents can stay with their children. This meets the child welfare goal of maintaining parent-child attachment, in a safe place, while also supporting the parent's journey into recovery.

Another approach is a modified form of peer to peer support, a proven practice in drug treatment. Some jurisdictions are instituting a role called "Parent Mentors" or "Parent Navigators" or "Parent Advocate" for child welfare–involved parents who are working on recovery. This program assigns parents with resolved child welfare cases (and who have been successful in staying clean and sober) to mentor parents just entering child welfare. They support the parent in both recovery and child welfare goals. Initial research is under way on this use of peer support in child welfare; though anecdotal information is promising, research results have yet to be published.

Community Attitudes Within the context of permanency planning, courts and child welfare workers must decide how free of substance

use a home must be in order to provide a safe environment for a child. Does the home have to be completely free of substance use to be a safe home for the child? How is it possible to monitor, over a period of years, the extent of substance use in a home? Is the community ready to put in place supportive services for a family over a period of years in order to provide protection in place of relapse? Is the community ready to provide the transportation and child care necessary if a caregiver parent is to engage in long-term outpatient treatment? What can be said about the race and class disparities found in referrals, access to treatment, and entry into child welfare? Admittedly, the answers to these questions are case specific, but the answer will lie in the degree to which any potential use or abuse poses an issue for the child and in whether there are protections in place in case of relapse. The answers may be indicators of the commitment to maintaining children with their own families. The daunting problems of these families have been difficult to resolve. Protracted collaborative and community-based effort over a span of time is needed.

Emerging Concerns in Permanency Planning

Legislation seldom solves a problem as neatly as it intends. An important intended effect of ASFA was to energize both the child welfare system and the parents of placed children, so that prompt provision of services by the agency and energetic involvement in use of services by parents would result in short stays in foster care. The child welfare agency must demonstrate in court that it has made "reasonable efforts" to provide services and engage parents in their use (and under ICWA, "active efforts"). The intent of the legislation was to end the long periods of time in which children remain in foster care while parents either receive few services or engage only marginally in the use of services. The intent was that increased judicial oversight and shorter timelines would result in shorter stays in foster care and increased numbers of children returning home.

The impact both on adoptions and on preservation of children's own families is indicated by the data. There is evidence that child welfare workers are becoming more effective in reducing numbers of children in foster care. In 1998, the year after ASFA was passed (and before it had time to take effect), there were 600,000 children in foster care. In 2011, there were 400,500.[18] Lengths of stays have shortened, as was hoped; in 1998, 32 percent of the children in foster care had been in care for three or more years; in 2011 only 20 percent had been this long in foster care. Once in foster care, however, children in 2011 were less likely to go home and more likely to be adopted. Of the children who exited foster care, in 1998, 60 percent were reunited with their original families; in 2011, 52 percent returned to their original families. About the same percentages went to other relatives during those years. The larger change was in the percentage adopted, 15 percent in 1998 and 20 percent in 2011 (U.S. Department of Health and Human Services 2012b). This rough comparison of "before" and "after" years provides some support to those who criticize ASFA as tilting the child welfare system toward adoption (Beem 2007).

In the twenty years after the passage of the law, there have been additional federal initiatives to promote adoption of children in foster care, most notably President Clinton's Adoption 2002, which established bonuses for states that increased adoptions. States have also had various initiatives.

Jurisdictions vary on whether courts will terminate the rights of parents who appear to be trying but who have not succeeded in recovery enough to care for their child. Noonan and Burke found that perceived adoptability of the child tended to be part of the decision as to whether to terminate parental rights (Noonan and Burke 2005). This is an alarming finding, suggesting that the law does, indeed, seem to have tipped child welfare toward adoption as a way to create permanency for children in foster care.

With its emphasis on adoption, ASFA suggests that adoptive homes can be found for any child currently in foster care. This probably cannot happen within existing resources and within the existing parameters of adoption. However, the quest for permanent homes creates an opportunity for the emergence of new forms of adoption, new forms of permanency, and new ways for parents to remain in the lives of their children. For example, ASFA allows tribal use of "customary adoption" (establishing legally binding ties with a new parent without termination of parental rights of the original parent). The Fostering Connections Act created the Guardianship Assistance Program, providing subsidy for guardianships as well as adoptions. This allows family members to shift legal permanence to a more reliable parent for the children without the painful adversarial process of a termination of parental rights.

There is an ethical question at the core of permanency planning. We know that it is best that children grow up in stable homes, and a legally permanent home is the best guarantee of this. We know that children grow best in their own families and retain attachment to those families, often seeking out their biological families when they become adults. If it proves that the characteristics of the children do seem to be an important factor in the decision to terminate parental rights, we do need to ask whether child welfare workers are doing everything possible to rehabilitate the child's original home or whether workers are succumbing to the desire to engineer perfect homes, according to their own standards, for children. ASFA placed great power in the hands of the child welfare system, and the use of this power needs to be carefully monitored.

Alternate Approaches to Permanency

Sometimes, neither return home nor adoption is an option for a particular child. An older child, even though unable to return home, may not want to be adopted because the original parent-child bond is so strong. Relatives may not wish to upset delicate balances within the extended family by participating in the often adversarial court processes involved in the termination of parental rights. For some children, particularly older children and/or children with serious difficulties, foster parents may not want to adopt, but may wish to have the continued supports the agency can provide. Courts are often protective of parental rights and sometimes refuse to terminate them even when children cannot return home. But these are not reasons to abandon permanency planning for children; indeed, children in such situations are even more in need of creative planning to secure for them a home where the intent is permanency even in the absence of legal support.

Court-ordered guardianship, which transfers most responsibility and authority to make decisions concerning a child's life (such as consent for medical procedures), is increasingly being used to secure legal support for placements in which adoption is not a good option. Guardianship transfers some decision-making responsibility from the state to the caregivers of the child. It provides a permanent legal structure to support lifelong emotional connections without requiring termination of parental rights.

With the Guardianship Assistance Program (GAP) created by the Fostering Connections Act, many grandparents, aunts, uncles, and close family have been able to receive the support of the child welfare system in caring for their kin, similar to the support adoptive parents receive when adopting a child who has been in foster care. This has been especially welcome by communities with long-established cultural traditions of kin or extended family members stepping up to care for children when parents are unavailable.

Foster care placements with relatives can be long term and stable, but foster parents may continue to want the resources available from the child welfare agency. While guardianship can provide some legal support for these placements and some protection from erratic interference by the biological parents, there is

a reduction in caseworker visits, medical consultation, and other services; this reduction in perceived state interference may be welcome or it may increase reluctance to change status from foster parents to guardians or adoptive parents. Reluctance to adopt or establish guardianship has been documented most often in cases where the needs of the child are so extensive that foster parents count on the financial resources and professional guidance of the child welfare agency behind them as the child grows (Meezan and Shireman 1985). Long-term foster placements are second-best solutions, in that they lack the legal supports of guardianship or adoption and continue to demand agency involvement, but they do represent a kind of supported stability for children.

Conclusion

The framework of child welfare services is complex, and the reader may feel that a maze of laws and agencies and systems has been introduced in this chapter. A framework takes on dimension as it is filled in with the detailed picture, and it is the following chapters about child welfare practice that will provide this picture.

The need for interdisciplinary and intersystem collaboration is evident even from this brief exploration of the many systems that interact to provide for the protection of children and for services to enhance their well-being. Such cooperation will require increased understanding by all players of the various systems' distinct goals and funding streams, their definitions of the primary client, their value systems, and their modes of working. The potential for interdisciplinary work and intersystem collaboration has been demonstrated in a variety of special projects around the country, but maintaining and expanding this will demand constant, thoughtful attention and work.

Unique to the child welfare system, and often difficult for workers in other systems to understand, is the focus on children as the primary clients and the quest to move children rapidly into permanent homes. This policy, legislatively mandated, is in accord with our knowledge of child development. And the child welfare agencies are successful: an astonishing 78 percent of the children who exited foster care in 2011 went to a permanent home.[19] Given the multiple difficulties of many families, the short timeline seems problematic to those working in other systems. The issue has been highlighted in work with the large numbers of families in which parents abuse substances. Implementation of the legal framework to expedite permanency for children needs to be carefully monitored to be sure that everyone involved is protected.

This needed oversight is primarily provided by the courts. Federal programs such as the CFSR are another set of watching eyes. And the informal oversight of the press provides a check on both the policy and the implementation of policy. Additionally, the worker in the child welfare agency, actually interacting with families and children, is in an important position to evaluate the impact of any policy. Through advocacy for their clients, backed up by data gathered during the course of their work with children and families, workers can provide the impetus for needed policy adjustment or change. Such advocacy is an important professional responsibility of the social worker and the child welfare worker.

NOTES

1. More information about this review as well as state by state and national reports on the CFSR findings are available at www.acf.hhs.gov/programs/cb/monitoring.
2. The Information Memorandum can be found at www.acf.hhs.gov/sites/default/files/cb/im1204.pdf.
3. John Chafee was a senator who had worked for many years on the development of legislation to meet the needs of this group of youth. He died shortly before the Foster Care Independence Act was passed, and the legislation bears his name.
4. The Hague is the third largest city in the Netherlands, the seat of Dutch government, and a center

of international relations. It hosts many organizations of the United Nations, including the International Court of Justice. The international treaty to regulate international adoptions was negotiated in the city of The Hague and thus takes its shortened name from that city.

5. The Council on Accreditation is a nonprofit accrediting organization that develops accreditation standards and works with agencies to help them meet the standards. There is more information on its website (www.coanet.org).
6. Chapter 2 of Downs et al. (2000), *Child Welfare and Family Services: Policies and Practice*, has an excellent summary of Supreme Court cases that have established the principles reviewed here. Much of the material of this section is drawn from that source.
7. Michael Shapiro in *Solomon's Sword* (New York: Random House, 1999) explores this question thoroughly and thoughtfully.
8. More information about aspects of a model juvenile court can be found at the National Council on Juvenile and Family Court Judges website (www.ncjfcj.org), and additional information about legal and court practices can be found at the American Bar Association Center on Children and the Law website (www.americanbar.org/groups/child_law).
9. For an excellent discussion of the importance of schools in child welfare work, see A. N. Maluccio, B. Pine, and E. Tracy, *Social Work Practice with Families and Children* (New York: Columbia University Press, 2002).
10. Karr-Morse and Wiley (1997), *Ghosts from the Nursery: Tracing the Roots of Violence*, presents a thorough and very readable discussion of the emerging knowledge of the effects of maltreatment on the development of the brain.
11. Note a Florida legislative initiative to increase the use of managed care at the same time that a review of outcomes demonstrated that four out of five pilot projects were failing to improve services (Albowicz 2004).
12. For example, a series in the *Denver Post* about Colorado's largely privatized foster care system, in which 57 percent of foster children are placed in homes supervised by private businesses. The lead story not only reported serious maltreatment occurring in inadequately supervised foster homes but also described the flow of public funds to support these foster care businesses, which were considerably more expensive, but seemed to be providing essentially the same level of care as public foster homes (P. Callahan and K. Mitchell, "Foster Care too Often Fails to Keep Kids Safe," *Denver Post*, May 21, 2000).
13. For examples, see the websites of Foster Youth in Action (www.fosteryouthaction.org/) and Foster Club (www.fosterclub.org).
14. One source for more information about family meetings is the National Family Group Decision Meeting Resource Center (www.fgdm.org) at the Kempe Center.
15. For one example see *RISE*, a magazine by and for birth parents of children in foster care and an organization that convenes parents (www.risemagazine.org). Also, Parents Anonymous (described in chapter 4) has also been active in creating certification processes for parent leaders.
16. See www.ffcmh.org.
17. For example, Unger, Dwarshuis, and Johnson (1977), in *Chaos, Madness and Unpredictability*, documented the work of Spaulding for Children, a Michigan placement agency that pioneered in adoptive placement of older children.
18. The reader will recall from chapter 1 that rates of child neglect were basically steady during this period, though child abuse appears to have declined.
19. Table 6.4 in chapter 6 displays these data.

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3

Child Protective Services

It doesn't seem to matter what kind of a mother a child has lost, or how perilous it may be to dwell in her presence. It doesn't matter whether she hurts of hugs. Separation from mother is worse than being in her arms when the bombs are exploding. Separation from mother is sometimes worse than being with her when she is the bomb.

—Judith Viorst, *Necessary Losses*

The first chapter explored the changing nature of the problems that the community recognizes as affecting the welfare of children. The second described the child welfare system that the community has put in place to help families deal with these problems. This chapter is about child protective services: the community's procedures to intervene in family life, when necessary, to keep children safe. Child protective services are a core service of child welfare. Many parts of the system stem from this protective function. Later chapters will discuss the array of child welfare services, including programs to support families in the care of their children at home as well as planning for out-of-home care when necessary.

When children cannot safely remain with their own families, the state intervenes, either to provide services to make the family safe for the children or to provide alternative safe care. Always open to question is the degree of risk that can be tolerated by the community, and this changes over time. The right of the state to intervene when children are reasonably safe but when the family does not provide adequate nurture, reasonable discipline, acceptable medical care, or educational opportunities is also often debated in the community.

Child welfare philosophy and thinking rests on the premise that children are individuals, and so have rights, most basically the right to have their needs met in at least a minimal fashion. Children do not "belong" to their parents, but to themselves. The state will intervene to protect the rights of children and to see that their needs are met if parents fail in this responsibility.

Child welfare shares the value system of social work, but differs from other areas of social work in that it places primary emphasis on the child. The "best interests of the child" guide interventions in child welfare—though how these best interests are to be determined is often open to debate. Because children grow best in families, services are increasingly focused on supports to strengthen the family and community. But the well-being of adults, including parents, is subservient to the well-being of children in child welfare policy and practice, and this distinguishes it from other social work enterprises.

How Child Protection Works

One needs a map to understand the child protection system. The following paragraphs are an overview, with details provided in subsequent parts of the chapter. A diagram as an appendix to the 2013 Children's Bureau publication "How the Child Welfare System Works," and found at www.childwelfare.gov/pubs/factsheets/cpwork.pdf, will give you a visual map of the system. Child protective services begin with a report, to a child abuse hotline or to the police, from

someone who is concerned about the child and thinks there may be abuse or neglect. The report is received by a screener, who attempts to gain as much information as possible about the circumstances of the child. If the situation does not meet the state's definition of child abuse or neglect, it will be "screened out." Sometimes the screener suggests other community services that might help. If the situation does meet the state's legal definition of abuse or neglect, the report is "screened in."

In traditional protective service, a "screened in" report is investigated by a protective services worker, who determines if the abuse or neglect actually occurred and if it falls under the state's legal definition of maltreatment. If the worker thinks that there was abuse or neglect and that the child's safety is at risk, the report is "founded" or "substantiated" and further action is taken. The worker then must make a critical decision: is the child safe enough to leave at home while workers attempt to help the parents toward better parenting or is the child in sufficient danger that he or she should be immediately moved to out-of-home care. If the child is moved to out-of-home care, the court must approve the move and will supervise the placement. There will be a series of court reviews throughout the time the child is in care. Whether the child is in out-of-home care or remains with his original family, services are provided with the goals of reunifying child and family and strengthening family functioning.

Traditional child protection services are distinct from other child welfare services in several important ways: (1) services are authoritative (the agency initiates the service, and the family is an involuntary client); (2) services carry increased social agency responsibility (decisions must be accurately made, and the agency cannot withdraw until the child is safe); (3) the community expects the protective service agency to carry out its work effectively; and (4) protective services must maintain a delicate balance in the use of authority, including the authority of the legal system, in relation to the child, the parents, and the community (Downs et al. 2000). These attributes make protective services extremely demanding and complex; they do not negate the principles of good social work practice.

If the screener thinks that safety concerns and risk are moderate or low, the case may be "screened in" and assigned to alternative response, or differential response. In this response, there is no investigation and no legal substantiation of child abuse or neglect, but the worker makes an assessment of the situation and works with parents to link with community resources that might be helpful. Parents enter services voluntarily. The interaction with the child welfare system is less intrusive with this response, and it is hoped that families will engage in services. This response pattern is discussed in more depth later in the chapter.

Community interest in protective services is intense. Media join in the debate about whether children too often remain with families when they are at risk of harm or whether child protective services too often removes children from attentive, if overwhelmed, families. The debate is often framed as a question of "family interest" versus "the best interest of the child." There are not really two sides here, for the best interest of the child usually lies in the preservation of the child's own family. Public discussion focuses on a vast middle ground of cases, in which the threats to a child's safety and the strengths of a family are not easy to determine. Unfortunately, errors can have devastating consequences. Publicity about child fatalities fuels the debate. Corresponding data about the emotional damage to children in foster care have focused on inadequacies in the foster care system. Only recently have these data led to thinking about whether children's own families might have been strengthened so the children could stay in them and about the development of alternative response systems.

The Development of Services to Protect Children

Communities have standards for the care of children. These standards are different now

than they were at some other periods of our history, but they have always been present. The term *minimally adequate care* is often used to describe the community's basic standard for meeting the needs of children. A brief historical venture will illustrate these changing standards and responses.

Saving Children

For the first two centuries of this country's history, the mode of providing for children whose care was inadequate was to "save" them from their families. These were primarily the poorest of families, and the removal of the children was often justified as a means of preventing the children from developing "slothful ways of life that led to idleness and moral degradation" (Costin 1985:35). The legal basis for intervention was established gradually, following the English common law principle of *parens patriae*, the concept of the state as responsible for the well-being of its youth. The children were usually placed in institutions, from which they were often indentured in order to learn a trade. Placement of children in foster homes began in the mid-nineteenth century. (Chapter 6, Investment in Foster Care, begins with a summary of the history of the use of varied placement alternatives in the United States.)

Rescuing Children

Child rescue was a distinct social reform movement that sought to establish the rights of children and to establish the responsibility of the state to discover and rescue children who were being abused or neglected. The responsibility of government to protect children began to be recognized about 1825. In 1872, a "deeply concerned lady" wrote to the *New York Times*, "Do not forget the creatures whom God made in his own image, and to whom he has given a soul that may be saved by saving the body. These dumb creatures [animals] will not meet you in the life to come, but if you rescue but one human being, angels will envy your reward" (Costin, Karger, and Stoesz 1996:61).

Societies with the specific mission of protecting children first emerged amid the publicity following the discovery of a badly abused and neglected little girl, Mary Ellen, in New York City in 1873. Laws on the books that punished those cruel to animals were invoked, with the idea that surely children deserved the same protection that animals enjoyed. Elbridge T. Gerry, the attorney in the case of Mary Ellen, became the first executive of the New York Society for the Prevention of Cruelty to Children when it was formed in 1875 (Downs et al. 2000). By the early twentieth century, there were three hundred such private societies dedicated to protecting children, "under the umbrella of the American Humane Association," in the Northeast and the Midwest (Schene 1998:26).

Sharing the philosophy of the animal protection movement, which was the original focus of the American Humane Association, the New York Society for the Prevention of Cruelty to Children sought to rescue children from bad families and to punish the parents who maltreated them. Gerry, in 1872, in an address to the National Council of Charities and Corrections, stated the purpose of the society: "Our object is . . . to rescue the child who is being ill-treated, and to deter the brutal from similar acts by bringing to punishment all those who injure children" (Costin 1985:43).

Competing Philosophies

Competing ideas about helping families and children developed during the Progressive era. The Charity Organization Societies wanted to understand and eliminate poverty. Poverty was thought to be both the fault and the responsibility of the individual, and the friendly visitors of the Charity Organization Societies were to "provide a role model, advice, and instruction" so that the poor could "rid themselves of poverty." Though it soon became apparent that the poverty of many families was due to circumstances beyond their control, the idea of working directly with intact families to resolve problems would have a major impact on social

work (McGowan 1983:56). A second philosophy was that of community action to improve conditions for families, and thus to improve conditions for children. The settlement house movement, the formation of labor unions to bargain for living wages, the advocacy for public education and the end of child labor, the mothers' pension movement—all were part of this thrust.

Although the child rescue movement also engaged in community advocacy, that advocacy was focused on building a system of legal rights for children, and the child rescue movement emphasized its distinction from other social movements (Costin 1985). The ideas of the Charity Organization Societies and of the settlement house movement began to influence some societies, though Gerry stoutly resisted them. The Massachusetts Society for the Prevention of Cruelty to Children, under C. C. Carstens, was noted for its emphasis on work to strengthen families; when, in 1921, Carstens became director of the new Child Welfare League of America, these ideas became dominant. The new philosophy of child protection included work with families, temporary out-of-home care and an attempt to preserve the child's own family whenever possible, and some emphasis on prevention of abuse and neglect (Costin 1985; Schene 1998).

Increasing Recognition and Government Responsibility

These developments "set the stage for what were to become the hallmarks of the child welfare field during the twentieth century: bureaucratization, professionalization, and expanded state intervention in the lives of children" (McGowan 1983:59). The Children's Bureau was founded in 1912, the first recognition that the federal government had responsibility for the welfare of children (McGowan 1983). The Social Security Act of 1935 was another step in the entry of the federal government into child welfare, with Aid to Dependent Children, which provided an entitlement to a basic income, and Title IV-B, Child Welfare Services, which provided limited funding to states for protective services. Publicly funded agencies began to take over the protective functions formerly carried out by private Societies for the Protection of Cruelty to Children (Schene 1998). Still, until the middle of the twentieth century, child protection was a minor part of child welfare work; the major thrust of the field was toward improving conditions for all children.

The focus shifted toward child protection in the 1960s after the discovery of what came to be called the "battered child syndrome" (Kempe et al. 1962). Pediatric radiologists began to recognize a pattern of multiple fractures of the long bones of very small children. Such fractures, in different stages of healing, could only be the result of severe physical abuse over time. It was hard to imagine that parents or other caretakers could deliberately and repetitively hurt children. At first it was thought that this must be a rare occurrence. The extent of physical abuse of children was first documented in a national survey of hospitals, which found 302 children in hospitals because of physical abuse (Kempe et al. 1962). The discoveries of the pediatricians astounded and horrified the public.

Over the next decade, many new state laws aimed to protect children from physical abuse, and in 1974 the federal Child Abuse Prevention and Treatment Act (CAPTA) was passed. It laid the legal framework for the development of protective services as part of child welfare, the framework still in use today.

Out-of-home placement became a primary means by which child protection agencies kept children safe. Most children were placed in foster care, a solution that protected them from their original home's maltreatment but exposed them to the trauma of separation from parents, to potentially long stays in foster care, and to multiple moves while in foster care. In the 1970s, a movement began to find permanent homes for children in foster care—either

back to their own homes or to adoptive homes. Permanency, along with safety, became the outcomes by which child welfare services were judged.

Over the past decade, there has been increasing concern about the welfare of children in the foster care system. Simply ensuring safety while children were in care was not sufficient to meet their needs. This concern was reinforced by research outlining very poor outcomes for children who had grown up in foster care (Pecora et al. 2010; Courtney et al. 2011).

Emphasis on the well-being of children has grown with the increasing understanding of the impact of adversive childhood experiences on adult functioning, as demonstrated in the Adverse Childhood Experiences Study (ACES), and as demonstrated by neurologic studies showing the impact of chronic stress. The well-being of the children in the child welfare system and the services that support that well-being have come into focus with reports from the National Survey of Child and Adolescent Well-Being (NSCAW) and the outcome data of the Child and Family Services Review (CFSR).

With these developments, there was greater reluctance to place children in foster care, though when workers were uncertain about a new type of risk to children, it was their initial response. This is well illustrated in the development of services for family violence.

Family Violence—A New Challenge

Only in the past twenty years have child welfare services intervened in situations of family violence. The initial response of child welfare workers was to remove children from a home in which there was family violence. Domestic violence organizations tended to focus on the mother as victim, and protested the removal of children as re-victimizing her. Their goal was to separate the mother and her children—together—from the violent family member.

As these protective services have worked more with family violence, these two protective agencies are increasingly making attempts to work together. Conflicting goals create a major obstacle to collaboration: child welfare workers focus on child safety and tend to blame mothers for not protecting children, while domestic violence organizations tend to trust the mother's judgment and work to empower the mother. Successful collaboration seems to depend first on articulation of common goals and recognition of the need to protect children without re-victimizing the mother.

A growing body of research makes clear that many family factors interact to mitigate or exacerbate the risk of harm in family violence. Recent research would suggest that separation from a mother, perceived by the child as protective, may exacerbate the developmental damage done by witnessing violence, as the person supporting the child in managing the trauma is removed (Carpenter and Stacks 2009). Some mothers compensate for exposure to violence with exceptionally nurturing interactions with their children (Letourneau, Fedlick, and Willms 2007; Casanueva et al. 2008). Safety assessments must consider safety in the context of individual caretakers and individual children.

The NSCAW reported that families with active domestic violence were more likely to be substantiated for abuse or neglect, but caseworkers did not identify the violence as an important factor in their decision making. Children from families with child maltreatment and domestic violence were, however, more likely to be placed in foster care (Kohl et al. 2005).

Understanding Abuse and Neglect

One difficulty in providing effective protective services is that we do not have much idea about what causes child abuse. The review of the research literature in chapter 1 indicated that many things are associated with maltreatment.

Until the causes are better understood, however, the design and targeting of services will remain problematic. The pursuit of that understanding takes place within a variety of theoretical frameworks, such as those emphasizing psychological profiles of the parent(s), socioeconomic explanations, and ecological frameworks that emphasize the interaction of parents, child, and environment (Giovannoni 1985; Pecora et al. 2009). The framework used by a child welfare worker can have considerable impact on the services provided.

Interactive or ecological frameworks are familiar to social workers and seem to make sense in the context of child abuse. This model is currently accepted as the best explanatory model in the field to date (Scannapieco and Connell-Carrick 2005:26). The multiple layers of an ecological model include the developmental history of the parents, where early experiences may predispose them to certain behaviors much later in life. The family system can provide a supportive network for parents or, if family relationships are strained, can exacerbate difficulties.

Community is the next level of the ecological model, with families receiving guidance from community standards and support, or lack of support, from community interactions. Many of the factors that are associated with child maltreatment are community factors—poverty, unemployment, violent and/or disadvantaged neighborhoods. These community factors place stress on the family and in interaction with family patterns and parental developmental history can result in maltreatment of children.

The individual, the family, and the community are all embedded in a larger culture, which in many ways shapes behavior. The United States is a violent culture with a high homicide rate, tolerance for guns, and a history of use of physical force to take over the land from its original inhabitants. It is a culture that has condoned physical punishment for children, with questioning of this method of discipline really arising only within the past twenty years. Racism is an integral part of this culture, placing stress on families as well as limiting educational and economic opportunities.

> The appropriate application of the ecological model emphasizes the role of culture in examining each of the levels. Parent, child, and family expectations may differ depending upon the family's culture. Family conflicts may be explained by culture-prescribed role expectations and issues surrounding acculturation. The macrosystem must be explored within the context of the family's values regarding parenting and discipline, but it must also include issues of racism and discrimination. (Scannapieco and Connell-Carrick 2005:30)

An encouraging example concerns a population in which poverty and powerlessness have not predetermined child maltreatment, but culture has been protective. Hispanic families, among our poorest families, are not overrepresented in child maltreatment statistics, in foster care, or in fatality statistics. This may mean that protective services are not reaching effectively into the Hispanic community and that these children are not receiving the services they need. Or it may mean that there is something protective in the Hispanic family structure. A California study has suggested the latter, finding traditional family structure more intact, with Hispanics exhibiting higher rates of labor force participation and higher rates of family formation than those of African Americans or whites (Hayes-Bautista et al. 1992, reported in Costin, Karger, and Stoesz 1996). Hispanic people are, of course, of many different origins. The group studied probably was primarily of Mexican origin, a people in the process of moving from abject poverty to something better. Hope may be an important factor. This is an aspect of our national life that needs further study, for we know very little about the factors that hold

family life together in the midst of poverty and disadvantage.

Protecting Children

Major legislation affecting child welfare services was outlined in chapter 2. This section presents a more extended discussion of the services developed under these laws and of the issues that have arisen.

Reporting

CAPTA mandated that states establish means for reporting child abuse and neglect. All citizens were encouraged to report any maltreatment. Additionally, in most states, certain professionals were designated as mandated reporters, meaning that they must report any knowledge of child maltreatment. All reporters are given immunity from prosecution for libel.

Massive publicity campaigns informing the public about the existence of child abuse and how to report it took place in the 1970s. These campaigns accomplished their intent of bringing children in need of protection to the attention of authorities that could protect them; they also had unforeseen effects. "The idea that all suspicions could be investigated seemed feasible in the 1960s, when physicians naively estimated that perhaps 300 families nationwide battered their children" (Schene 1998:10). But, as shown in figure 3.1, the number of reports has grown steadily, reaching more than 3 million by 2011 (U.S. Department of Health and Human Services 2012a).

The protection of children presents potential conflicts with the civil liberties of parents and families. Without a doubt, a protective service investigation is invasive of family privacy. Families are fearful of state intervention and fearful of the state's power to remove their children from their homes. Attempts to improve the identification of abuse led to registries of children injured, so that a child with multiple injuries over time could be identified, even if taken to different hospitals and doctors. However, these registries contained names of adults suspected of abuse, with no proof that it had occurred, a violation of a basic legal presumption of innocence until guilt is demonstrated. The age of computers has made the checking of data systems and the sharing of information so easy that the issue assumes even greater importance. Purging computerized records of unfounded abuse or neglect complaints solves one problem but destroys the capacity of the protective service agency to track multiple complaints over time about the same family. Issues of confidentiality and the sharing of information among agencies remain.

Social workers are mandated reporters. This means that if, in the course of work with an individual or family, a social worker learns of

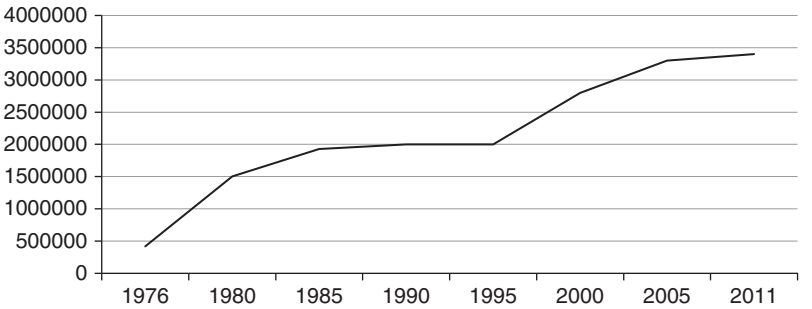

FIGURE 3.1. Number of reports of abuse and neglect over time *Source:* Kadushin and Martin (1988) and NCANDS 2012 (U.S. Department of Health and Human Services 2012a)

child maltreatment, that maltreatment must be reported to child protective services. This creates a dilemma in some instances. If the social worker thinks that the services offered by the local protective service agency are intrusive and authoritarian and will do more harm than good, there is understandable reluctance to report. If the social worker has a good relationship with the family, there may be fear that reporting will be seen as betrayal, disrupt that relationship, and result in the family not receiving needed help. However great the temptation not to report may be, the social worker must keep in mind that there is a legal obligation to report. There is also an ethical obligation, for most social workers do not have the specific training and skills to deal with child maltreatment. And there is the obligation to advocate for changes in the local protective agency response, so that it is more certain that a family and child will be helped by the report.

Legal Definitions of Abuse and Neglect

When a report of possible maltreatment is made, the immediate response of the child welfare agency is to attempt to learn more about and substantiate the maltreatment. The process begins when a screener, receiving a report of suspected child abuse or neglect, applies the law and definitions of the state to the description of the reporter. He or she is attempting to determine whether abuse or neglect, as defined in the statute, exists. For about 39 percent of the reports, the screener will decide that the report does not meet the statutory definition of child abuse or neglect. These reports are "screened out" and typically receive no further service (U.S. Department of Health and Human Services 2012a).

A continuing problem with reporting, and with centralized data collection, has been the definition of maltreatment. The laws of the fifty states differ, sometimes markedly. This makes it difficult to compile meaningful national statistics. The imprecision of definitions of maltreatment has also led to difficulties in interpreting the laws to the public, to criticism of child protective agencies for not acting in cases of perceived maltreatment, and probably to underreporting due to uncertainty about what should be reported. The issue of defining child neglect has been particularly problematic. An example of the definitions used by three different states illustrates the difficulty (box 3.1).

BOX 3.1

Hawaii's law is short and to the point:

- *Child neglect occurs when a child is not provided in a timely manner with adequate food, clothing, shelter, psychological care, physical care, medical care, or supervision.*

New Hampshire's law is more detailed and emphasizes the capacity of the caregivers:

"Neglected child" means a child

- *Who is without proper parental care or control, subsistence, education as required by law, or other care or control necessary for his or her physical, mental, or emotional health, when it is established that his or her health has suffered or is very likely to suffer serious impairment, and the deprivation is not due primarily to the lack of financial means of the parents, guardian, or custodian.*
- *Whose parents, guardian, or custodian are unable to discharge their responsibilities to and for the child because of incarceration, hospitalization, or other physical or mental incapacity.*

Arizona's law emphasizes substance abuse:

Neglect or neglected means

- *The inability or unwillingness of a parent, guardian, or custodian of a child to provide that child with supervision food, clothing, shelter or medical care if that inability or unwillingness causes unreasonable risk of harm to the child's health or welfare.*
- *Permitting a child to enter or remain in any structure or vehicle in which volatile, toxic, or flammable chemicals are found or equipment*

is possessed by any person for the purposes of manufacturing a dangerous drug.

- *A determination by a health professional that a newborn infant was exposed prenatally to a drug or substance listed in #13–341 and that this exposure was not the result of a medical treatment administered to the mother or the newborn infant by a health professional.*
- *A diagnosis by a health professional of an infant under age 1 with clinical findings consistent with fetal alcohol syndrome or fetal alcohol effects.*

Minnesota distinguishes the "commission or omission" of any of several listed neglectful acts that occur "by other than accidental means." Colorado includes "refusal to take reasonable action to protect the child from abandonment, abuse, sexual abuse, sexual exploitation, neglect or parental unfitness when the existence of the condition was known or should have been known." Medical neglect is often further defined in state law. Minnesota law states, "medical neglect includes, but is not limited to, withholding medically indicated treatment from a disabled infant with a life-threatening condition." Michigan, Florida, and several other states include a modification of the concept of medical neglect: "A parent or guardian legitimately practicing his or her religious beliefs who thereby does not provide specified medical treatment for a child, for that reason alone shall not be considered a negligent parent or guardian."

Thus the states, building on the common core of the federal definition and responding to local concerns, build their differing laws.

Statutory definitions of abuse and neglect are generally quite restrictive and are intended to inhibit intervention in family affairs unless serious harm has been done to a child or the child is clearly at risk of such serious harm.

Investigating and Substantiating the Report

Child protective work entails heavier responsibility and greater skill than most other social work. When a child protective worker makes an assessment of the safety of a home for a child, he or she must make a decision that could alter the course of a family's life. A decision to do nothing is as important as one to intervene. The decision to intervene entails another set of decisions about what the most effective intervention will be. The worker's skill in engaging the family in assessment and planning, while making firm use of the authority to protect children, will also have a profound impact on future work with the family.

Not all reports are investigated. Data from the Fourth National Incidence Study of Child Abuse and Neglect (NIS-4)[1] indicate that child protective service agencies investigate only a minority of the children that may have been abused or neglected, either because the incident was not reported to child protective services or because it was screened out without investigation. Investigation occurs for only 43 percent of the children who experienced harm from maltreatment and 32 percent of those thought to be endangered (Sedlak et al. 2010:16). Situations that are not reported or not investigated are, of course, generally those considered to be low risk, but the fact is that in each instance someone thought a child was in trouble and needed help.

When a report is received, it is important that the protective response be prompt. Usually, the screener identifies high-priority cases that demand an "immediate" response—these will be situations in which the child seems to be in imminent danger. State laws vary in their definition of how quickly an "immediate" response must be made: one to twenty-four hours is common. In cases of obvious, current risk, response often is immediate, and police sometimes make the response in order to intervene in a situation quickly (as happened in the case example we will follow in this chapter). Again, states vary in the statutory limits for making the first contact in less pressing situations: the range is from one to several days. In 2011, the median response time was three days (U.S. Department of Health and Human Services 2012a).

The situation of the R family provides an illustration of the interaction of child protective

services (child welfare and the police) and a family, as work is accomplished to increase the safety of the children (box 3.2).

BOX 3.2

When a neighbor saw the 3-year-old toddler on the roof of a two-story house, he called the police, who responded immediately. When they knocked on the door, it took a long time to get any response. The father had been asleep and had locked the children, a 5-year-old and 3-year-old twins, in a bedroom while he slept. When police gained entry, they found the house in "deplorable" condition. One of the 3-year-olds had climbed out the bedroom window and onto the roof.

The police, ready to take the children to foster care, called child protective services. When the mother came home from work, she found police and protective service workers still there assessing the situation.

The protective service worker may conceptualize the task in a number of different ways. If he is part of a "substantiation-based" system, intervention will occur only when there is evidence that the court is likely to accept that an incidence of maltreatment has occurred and is serious enough that punishment of the perpetrators (if only through removal of the child from their care) is justified. If the focus is risk assessment, the role of the protective service worker is not to determine whether a crime has occurred or who did what, but to determine more holistically the nature and extent of the future risk to a child based on an array of factors. Finally, the worker may focus on safety, attempting to determine the capacity of the family to ensure the child's safety.

Each of these approaches starts with investigation of the maltreatment—what has occurred, any prior history of maltreatment, how family members perceive the incident. If the child is to be removed from the home, the court will demand evidence that maltreatment was substantiated. In the case we are following, the R family, the evidence of lack of supervision, the child on the roof, was clear, though the circumstances that created this situation needed evaluation to assess the continued risk to the children.

When reports are investigated, in about three quarters of the situations reported it is determined that maltreatment serious enough to warrant state intervention cannot be demonstrated (U.S. Department of Health and Human Services 2012a). It is not known how many of these families with unsubstantiated reports are linked to community services that might help with whatever conditions prompted the report. The protective service agency's staff time is thus spent largely on investigation, with only a small proportion devoted to work with families and children.

Data thus document a large group of cases in which there are difficulties, but protective services are not mobilized. Unsubstantiated cases may represent inappropriate reporting or they may indicate unmet service needs in the community. The nature of the additional unreported cases discovered by NIS-4 is unknown. Any of these may be families that need help to prevent more serious maltreatment.

Alternative Response

The presence of this group of families with unsubstantiated cases was one of the factors behind the development of an alternative response system, sometimes called differential response. These are responses that are focused on providing voluntary services to support families. Being used increasingly, alternative response provides a gentler interface of the family and the child protection agency. This disposition focuses on the service needs of the family and the mobilization of services in the community to meet those needs. It embodies many of the practice tenets of good social work. It has been used mostly in situations judged to present low or moderate risk.

When a report is received, under the alternative response paradigm an assessment rather than an investigation is conducted by the worker.[2] The assessment "involves assessing the family's strengths and needs and offering

services to meet the family's needs and support positive parenting" (Child Welfare Information Gateway 2008:3). If risk is deemed to be low or sometimes moderate, a service package individualized to meet the family's needs is offered to the family on a voluntary basis. Alternative response can also be conceived of as a prevention model, providing a means to offer services to families that have been identified as being in situations that could develop into abuse or neglect (Conley 2007) or as another way of addressing risk of harm in a home (Fallon, Trocme, and MacLaurin 2011).

Alternative response might be a promising avenue for cooperative work in family violence situations. In fact, however, referrals that include family violence tend to be classified as moderate to high risk (English, Edleson, and Herrick 2005; Alaggia et al. 2013), and it is not clear whether alternative response models are going to be extensively used in family violence situations.

The descriptions of alternative response sound very much like the descriptions of best practices in traditional child protective services, and indeed the assessments use many of the same tools as a child protective services investigation (Child Welfare Information Gateway 2008). The difference is that at the end of an assessment, there is not a formal finding about the occurrence of maltreatment: perpetrator names are thus not entered into child maltreatment databases, nor is there typically court involvement. Assessments are less adversarial than a child protective services investigation and have a goal of engaging the family in appropriate services. Community agencies provide these services, and families use them on a voluntary basis.

The intent is to incorporate strength-based and family-focused practices into child protective services. This is a new approach to child protection and has been adopted by twenty-nine states, with significant variations in its implementation (Hughes and Rycus 2013). Additional states are in the process of developing an alternative response system.

A critical question is whether abandonment of the use of power by protective service workers will make children less safe. Several states have evaluated the results of use of the alternative response model, and all have reported that child safety, measured by reports of re-abuse within a six-month time frame, did not differ from the traditional protective services model (Child Welfare Information Gateway 2008). Children thus seem to be equally well protected.

Concerns that have been voiced generally center around the ability of community services to provide the services needed by these families. The availability of sufficient resources varies greatly among communities, with rural communities in particular often having few. Preventive services that work with at-risk families have long reported difficulty in sustaining client engagement; this may prove to be a problem for alternative response plans. The lack of continuing protective service involvement may result in some families, who briefly emerged, again dropping out of the community safety net. The voluntary nature of services does remove the protection, for both children and families, that the court provides.

The Rights of Parents

Though laws are generally written to give child welfare workers broad latitude in investigating a child maltreatment complaint, family privacy retains some protections. Only if a child is believed to be in danger may entry be made to the home without consent. Without a search warrant issued by the court, there are limits on the extent to which a worker can investigate the home or examine children. When a child is removed, parents have the right to notice of a hearing, to be present at a hearing, to be represented by an attorney, and to confront and cross-examine witnesses.[3] Usually, state law sets a definite period of time (often two or three working days) within which this hearing must occur. During the course of a placement, the court periodically reviews the status of the case, and the parents have the opportunity to

present their evidence that a child should be returned.

Federal law requires that social workers make "reasonable efforts" to maintain children in their own families and to reunite separated children and parents. This concept of reasonable effort is a mediating ground between the rights of parents and the need of children for protection. There are some exceptions, but caseworkers are required in almost all situations to document to the court that they have provided services to keep children and parents together, and this is an important protection for both.

Assessment of Risk

When a report has been substantiated, an assessment of the level of risk that the home presents to the child must be made. A risk assessment looks at strengths and risks in such domains as parental capacity (including whether it is compromised by substance abuse, mental illness, developmental delays, and so forth), level of family support, the child's age and developmental status, and any history of abuse in the parents' lives. There are multiple risk assessment instruments available, some built from consensus among experts or reviews of professional literature, some built from research identifying factors that predict recurrence of maltreatment. A good discussion of these instruments can be found on the Child Welfare League of America website (www.cwla.org). Research has demonstrated that use of these instruments can improve consistency in decision making, and formal risk assessment is now mandated by federal law.

In the case being followed in this chapter, child neglect (lack of supervision) was substantiated. However, the work in the case illustrates many of the elements of alternative response. The investigation seemed more like an assessment: the worker did not need to find proof that the father had been neglectful in supervising the child, as that was apparent in the first report that he was on the roof. So the family's strengths and needs were identified, and the worker suggested services that would enhance parenting and family life. The parents had not known these services existed, engaged in them, and found them helpful. This is an example of good practice in protective services.

In a continuation of the story of the R family, the worker and the parents began to assess the extent to which the family was able to keep its children safe from harm (box 3.3).

BOX 3.3

The mother: *"I was impressed, very impressed. Very happy that she was willing to work with us. She wasn't out to get the kids. She wasn't out to get us. She took a real impartial look at the situation. She wanted to see what the situation really was, and not what it just appeared to be at the time."*

The father explained that he was ill, and medication had made him sleepy. Once before when he had gone to sleep the children had gone outside, and neighbors had complained about the lack of supervision. He thought the children would be safe locked in the bedroom. The parents were aware of the danger the child had been in and were ready to take action. With the worker, they made a plan.

The father: *"She talked to you like you were a person instead of someone who had done something wrong."*

Parents and worker together decided that the children needed a clean, safe, and sanitary home, with safety locks on the windows. They needed to have parents who understood the children's need for safety and supervision, and a father awake, aware, and engaging with the children when they were his responsibility.

The Decision About Placement

The major decision made by the protective service worker is whether it is safe to leave the children in the home or whether for their immediate safety they must be moved to out-of-home care. A decision to leave a child in a home is as fraught with consequences as a decision to remove a child. The task demands a specialized knowledge of the impact of separation on children and of the techniques that can help a child deal with

the trauma. All the clinical skills of assessment and intervention used in social work are needed.

The decision to place a child in foster care has profound consequences for both child and family, and one would hope such a decision would be made only after careful risk assessment and analysis of all factors. Even if parents do not agree with the worker that the children need placement, the worker has the authority to remove the children. The judgment of the worker will be reviewed in the juvenile court within a specified time period, usually twenty-four hours or one working day. At that hearing, parent, child, and agency may each be represented by an attorney. The task of each attorney is to present the facts that will support the wishes of his or her client; with all the facts and arguments presumably before him, the judge makes a decision. The child may be returned to his family, returned with some protective supervision, or ordered into temporary foster care, with a review date set. The court review protects all parties.

If there is agreement on the appropriate plan for the child, the placement may be made voluntarily, without court involvement, as happened in the R family (box 3.4).

BOX 3.4

The plan they made was for a temporary placement of the children, a return home when the physical condition of the home had improved, and later some follow-up services to prevent future difficulties. The worker was firm that the children were not safe in the home, given the current condition of the home. They were placed with grandparents, whom they knew, for the weekend. Over the weekend the parents were to clean up the house. Locks needed to be installed on the windows.

Services Provided: A Brief Overview

Beyond the immediate protection of children, the goal of protective service work is to strengthen family functioning so that the children can remain safely in the home or, if placed, return soon, and so that the family can function without future crises. The services provided to achieve this goal are those of the protective service agency as well as other specialized community services to meet specific needs.

Service Planning

Engaging Families in Services When services are provided, it is important that services be tailored to fit the needs of the individual family. And it is important, if the family is to engage in the use of services, that the family sees the need for such help (Shireman et al. 2001). Otherwise, services will be viewed as a series of "hoops" through which a family must jump in order to get the protective service caseworker out of its life. Dumbrill (2006) identified power as the dominant theme in interaction between worker and parent, with parents fearful of the worker's power and "playing the game," unless they came to believe that the worker's power would be used to support the family.

When parents are poor, preoccupied with meeting basic needs, and angry at the intrusion of protective services into their lives, it is not easy to engage them in use of available community services. A court order may get them to a service, but the service must seem useful if they are to continue to participate. Too often, protective service agencies prescribe a "menu" of services to improve parenting—usually including parenting classes, often including anger management programs, substance abuse treatment, and counseling. The list is sometimes extensive enough that compliance is a logistical impossibility. And compliance becomes a key word—not what the family is gaining, but what it is doing. Families engage in the process of change much more readily if service plans are individualized to meet their needs and if they participate in the development of the plan.

Family Meetings Family meetings are used by many protective service systems that do not function in an authoritarian mode as a way to involve families in service planning. They give a family a voice in decision making, and they

can be effectively used to help a family make an appropriate plan.

The practice of family group meetings originated in New Zealand and is based on the philosophy that the family itself can best determine what it needs and how it can access resources. In family group meetings the family, after reviewing the situation with professionals and learning about available resources, is left alone to decide what should happen in the case. Family group meetings have been shown to reduce foster care placement as families come up with innovative plans to care for their children. Parnell and Burford (2000) suggest that these meetings can become a way for the protective service worker to pull together a team of "allies" to work together to strengthen the family and build a "sustaining community" for the family.

Family unity meetings were introduced in Oregon in the late 1980s, and the model has been widely adopted. These meetings are somewhat different in character from the family group meetings. They bring together all of those in the natural helping network who are involved in the problem—parents, grandparents, other relatives, church members, neighbors, as well as the protective service worker. In these meetings the problem is examined, and those present come up with suggestions for resolving it, often offering to help in the resolution. The protective service worker is present throughout the meeting and has the ultimate decision-making authority.

Another variant is the family decision meeting. This format emphasizes the inclusion of community partners in case planning; it is part of the effort to build a community system of care. A family decision meeting is a planning meeting of the immediate family, close relatives, and those professionals that may be involved in service delivery to the family; there may be several meetings as a case progresses. These meetings are well liked by community partners (such as mental health professionals, school personnel, and probation officers), and families also see them as a vehicle for having their ideas included in decision making (Shireman et al. 2001). However, families need extensive preparation for these meetings so that they know whom they may invite, can anticipate the number of professionals that will be there, and feel comfortable in expressing their ideas during the meetings (Rodgers 2000).

In an interesting twist, in each of these models the meeting is managed by a facilitator who is outside the protective services system and not a family member. The assumption is that the child protection worker and the family are adversaries, and the facilitator is needed to mediate between them. But the assumption of an adversarial relationship may not be valid when initial work of a protective service worker with a family has gone well.

The family we are following in this chapter's case example did not have a formal family decision meeting. Instead, planning was done in a series of meetings between the parents and the worker. A meeting might have increased the involvement of the grandparents and of community agencies. And, certainly, had it not been relatively easy to develop a plan, a family meeting would have been helpful (box 3.5).

BOX 3.5

The family participated in parenting classes and received some help in organizational and budgeting skills to improve home management. . . . The grandparents provided money for the locks for windows; had this not been possible, a fund was available within the agency to be used flexibly to make such purchases. In addition, the child who had been on the roof was tested for possible ADHD.

The father: *"She left about all of it up to us."*

The mother: *"Kind of guided it. At least she made it feel like it was up to us. I mean, if we had resisted, she might have said you have to do it. But she really went about it in a way; she left a lot of it up to us. . . . She was listening. She was opening up to listen to us about what we thought. . . . She pointed out, 'Well, maybe this is a need. Maybe parenting classes would help with supervision skills.' "*

Foster Care as a Service

In the example of box 3.5, the worker was successful in engaging the family in planning for the safety of its children. The children's immediate need for safety was met with a very short placement with grandparents—a weekend rather than a placement. Use of a family member meant that the children were with someone they knew and were comfortable. Had a longer stay been necessary, a process of certifying the grandparents as foster parents would have started. Had no grandparents been available, the worker would have had to decide whether the children could remain at home or would have to spend time in foster care (extensively discussed in chapters 5 and 6) with a family they did not know. The worker also mobilized some community resources, parenting classes, and evaluation of one of the children for ADHD. The parents had not been aware of these resources.

The Extent of Services

In 2011, 3.4 million referrals, involving approximately 6.2 million children, were received by child protective services. About two thirds were screened in. Of these, abuse or neglect was established or indicated in about a quarter of the responses. Of the children determined to be victims, three fifths received services of some type. Additionally, a third of the families where a complaint was investigated and not founded received some type of service (U.S. Department of Health and Human Services 2012a).

The extent of services received by those children who were found to be in need of protection is largely unknown. Many child protective agencies targeted services to the highest-risk cases, which unfortunately meant that many families who neglected their children, the most often reported category of maltreatment, received no services (English 1998). Bartholet (1999) reported that a review of New York cases revealed that half of the substantiated cases were closed on the same day they were substantiated. A California study found that 67 percent of the cases in which maltreatment had been documented were discharged from intake; it is not clear what brief services may have been offered during the intake process (Inkelas and Halfon 1997). Placement in out-of-home care occurred for 22 percent of the children whose maltreatment was substantiated (U.S. Department of Health and Human Services 2012a). Many of these placements may have been very brief, as was the placement of the child in our example.

Decisions to screen out reports may be influenced by workload pressures (Wells et al. 1989).[4] In their review of research and analysis of services offered as part of child protection, Faver and colleagues (1999) documented the lack of service delivery for many families and the inappropriateness of the services offered. With limited services available, families were offered what there was. Short-term services tended to be more available and were often used with families who needed long-term help. Many services were targeted toward a single problem, whereas families had multiple problems. Foster care may have been provided more often than necessary because matching federal dollars are available for state expenditures for foster care, regardless of the amount spent, whereas funds for treatment and prevention are capped at a fixed amount. And finally, if families have not been involved in the planning of their services, they may believe them to be inappropriate and engage in them only to satisfy the child welfare agency, which has the power to take or return their children.

These findings were echoed in the 1994 national study of service delivery, in which it was documented that brief service is common: 78 percent of the children in the child welfare system remained at home, and 64 percent of those cases were closed within three months. (If there was foster care, the median length of service was twenty-six months.) Parental substance abuse, mental health problems of either child or parent, and lack of housing were associated with long service periods (which usually included foster care). The most commonly

provided services were parent training, provided to 37 percent of the families, and mental health outpatient treatment, provided to 24 percent of the families. However, for only a quarter of families that were homeless or experiencing housing problems were housing services provided; educational services were provided for only 6 percent of parents lacking a high school diploma. Substance abuse services were provided to 17 percent of the families, half of those that workers thought needed such services (U.S. Department of Health and Human Services 1997).

These are appalling data, outlining a serious failure to protect children and to enable their families to care for them. It is the sort of data that triggered the CFSR reviews and the increasing implementation of alternative response systems in protective services. Though the recent reformulation of services to focus on the well-being of children, the increasing use of alternative response systems, and the CFSR may change these data, it is happening at a slow pace. The 2011 data show little change from the data reported ten years ago (U.S. Department of Health and Human Services 2002).[5]

It should not be thought that those who actually deliver services are unaware of the limits in services to children and families or that they are unconcerned. The uninvestigated cases, the unsubstantiated cases, and the substantiated but unserved cases represent families for whom intervention might be helpful but is not offered because resources are limited. The data do suggest that in traditional protective services, caseworkers are spending most of their time investigating reported abuse and neglect. Intervention, in conventional protective service response, tends to focus on high-risk cases, ignoring lower-risk cases and thus, perhaps, missing chances to prevent maltreatment (Conley 2007). There is also great variability in the availability of services, with rural areas having many fewer resources for families.

The Services Provided

Though establishing the safety of the child is the primary mission of protective services, another goal is strengthening families so that children may safely be with them. Less than a quarter of substantiated maltreatment incidents result in children being placed in out-of-home care (figure 3.2). More families work with community services while the children remain at home.

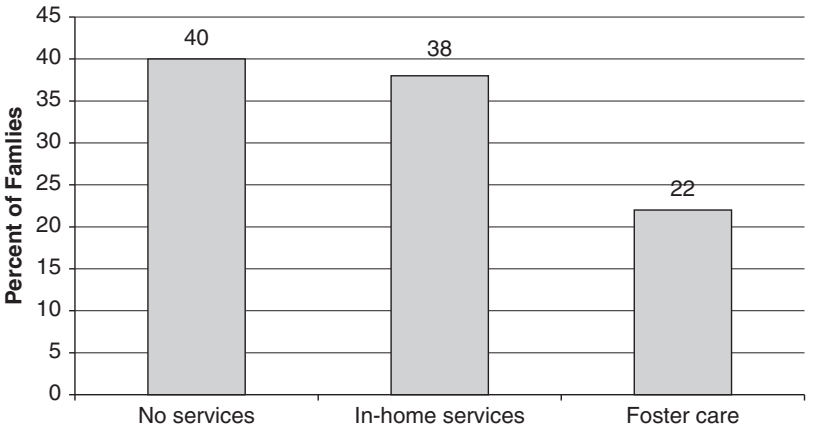

FIGURE 3.2. Services delivered to families with substantiated abuse or neglect *Source:* NCANDS 2012 (U.S. Department of Health and Human Services 2012a)

Community-Based Services Protective service workers refer their clients to an array of community services. Many are described in the following chapter. The protective service worker has the task of selecting the most appropriate of them for the family, referring the family to the service, and helping the family make the connections to get started.

The services that are available vary greatly in different communities. The second wave of the NSCAW provides a good description of services provided for the families in that large national sample. Among caregivers receiving services with the children in their homes, the most common services received were parenting skills training (55.1 percent), individual counseling (53.5 percent), job training and searching (47.7 percent), and family counseling (47.3 percent). Caseworkers were less likely to report referring these families for mental health (39.2 percent), substance use (24.7 percent), and housing (18.4 percent) services. Among caregivers whose child was in out-of-home placement, the services focused more on mental health services (64 percent), substance use services (64.8 percent), individual counseling (69.3 percent), parenting skills training (72.2 percent), and nonintensive services such as monitoring visits (73.8 percent). The data confirm the extensive use of parent-training services, and the different patterns suggest that services are being tailored to the needs of the families (Dolan et al. 2012).

However, the data paint a troubling picture of a gap between the perceived need and referral for a service and actually receiving the service. Among the families with children at home, despite a perceived need for mental health services (39 percent) and substance use treatment (24.7 percent) and a referral, these services were actually received by only about a third of the families. Families with children in out-of-home care fared better; about two thirds of these families received substance use and/or mental health services (Dolan et al. 2012).

A list of services is an incomplete picture; the way in which these services are delivered to families needs examination. Most families have multiple problems, and some are expected to complete an extensive list of services. Service agreements are drawn up—frequently dictated by the caseworker—and families are asked to "comply" with the agreement. Frequently, courts may mandate that families find safe and stable housing and/or obtain regular employment; child protective services offer little help in meeting these demands. The CFSR process is monitoring the use of more interactive ways of developing a service plan, such as family group decision meetings. This approach to services marks a real culture shift in protective services: as the CFSR process continues, it will be interesting to follow.

Foster Care as a Service Though we have been discussing family participation in service planning, it is important to remember that the protective service agency retains the power to recommend that the court order the use of services. It also retains the power to place the children temporarily in a foster home and, after this placement is reviewed by the court, to continue the separation of children from parents. Foster home placement is used sparingly in protective services, for workers are well aware of the trauma for a child that such an action creates and are well aware that temporary foster care placements can drift into long-term placements.

In 2011, of those children whose maltreatment was substantiated and who received services, two fifths were placed in foster care (U.S. Department of Health and Human Services 2012a). It is clear that, despite its reputation as an authoritative agency that wants to take children from families and put them in foster care, protective services focus on services to enhance family functioning while the children remain at home.

Cultural Competence Child protection services must, obviously, be responsive to the customs and needs of the diverse families

encountered by the system. For the protective service worker, the points at which cultural knowledge and sensitivity are most important are in making a connection with the family, gathering information related to substantiation of a report, and in making decisions about placement. Most child welfare workers and most administrators are white and usually from middle-class families. The dominant community's standards are likely to be internalized by the child welfare worker and the agency itself. In order to work effectively, the worker needs knowledge of the cultural norms and values of the major client groups served. It is also important that child welfare workers not apply standards of ethnocentrism when making the necessary decisions.

The first step is knowing the customs and language of those being served.[6] Acquiring knowledge of other cultures is perhaps the easiest step in gaining cultural competence. Curricula in schools of social work attempt to address this need, and the accreditation standards of the Council on Social Work Education include the demand that this knowledge be presented (McRoy 2013). Differences can be as important as the ways in which a culture is organized, such as orientation to time, and as subtle as good manners during a conversation. Cultural knowledge, in conjunction with evidence that the worker respects the parents and values their ideas, can help the worker engage the family in collaborative work.

In deciding whether maltreatment has occurred and in assessing the level of risk to the child, it can help to have clear definitions of abuse and neglect that are specific in describing serious deficiencies in child care. But they do not provide completely satisfactory answers. For example, definitions of neglect state that lack of supervision constitutes neglect—but patterns of supervision have cultural variability. Physical discipline delivered under a set of cultural rules can seem abusive within one cultural framework but not another. For some cultures, particularly people who have been oppressed, teaching instant obedience has been a way to keep their children safe, and physical discipline teaches instant obedience.

In order to make case-by-case decisions, the child welfare worker must translate knowledge and policy into workable practice guidelines. An important consideration is the examination of the internal cultural dissonance of any set of parental behaviors; if the behaviors are outside the usual practices of the culture, they are much more likely to be abusive or neglectful in the eyes of both the larger community and the subculture (Korbin 1981).

Culture includes social class, a variable that can introduce many differences in standards and expectations. We commonly ignore class differences, and there is a "politically correct" tendency to note that child maltreatment occurs in all socioeconomic strata. In fact, with the exception of sexual abuse, child maltreatment is concentrated in poor communities and poor families (Sedlak et al. 2010). Assessment and intervention must be carried out with understanding of the constant struggle faced by those in poverty, with recognition of ways of coping and managing that may be different, and with attention to the larger circumstances of the family as well as to family dynamics. If out-of-home care is needed, there must be homes in which the child's language is spoken, food provided is familiar, customs are comfortable, and inclusion in the ethnic community can be continued. The worker also needs to recognize that children of color may remain in foster care longer.

> A social justice perspective centers on social concern relevant to the disproportionate number of children of color vulnerable to harm, instability, and insecurity as a consequence of cultural misunderstanding, displacement, and disadvantage. Linked to this discussion are durable inequities exclusive to populations of color, inequalities that prevent social and economic mobility. These social consequences, accompanied by poverty, inadequate access to resources, and the like have

> strong correlates to child maltreatment. (Ortega et al. 2010:262)
>
> The system continues to concentrate on the effects of childhood poverty, but it treats the damage as a symptom of parental rather than social deficits. (Roberts 2002:33)

The overrepresentation of children of color in the child welfare system suggests that cultural differences marked by race are not well understood and/or not respected. This is a critical issue of this era in child welfare and the critical issue of this chapter (box 3.6).

BOX 3.6

Cultural issues with the family we are following were minor, for the worker and family were of similar backgrounds. The worker did, however, note a cultural difference with the police and discussed briefly her increased tolerance for poor housekeeping, developed in working with lower-class families whose housekeeping standards were different, but who successfully raised children: "They [the police] don't see homes like we see all the time. . . . They wanted us to come and remove the kids right away. Just get them out of there. . . . They see that narrow vision sometimes."

The family did not mention cultural differences in its interview.

Involving the Whole Family Though we speak of "family" and "parents," child welfare services tend to focus on the mother and ignore the father. In physical or sexual abuse situations and in family violence situations, the mother is blamed for not protecting the child, though the father may be the assaulter. When the charge is neglect, the mother is blamed for not caring for the child, because deeply ingrained is the idea that this is the mother's role. Fathers can leave families without being seen as abandoning them. Child welfare practice has thus created "ghost fathers" (Brown et al. 2009).

Fathers, however, are part of these families. Even absent or incarcerated fathers are part of the family and can play a role in strengthening it.[7] Recent literature has documented this ignoring of fathers. Fathers are rarely considered as placement resources; maternal grandmothers were more likely to be sought as a resource. It seems as though when caseworkers have identified one proactive parent, they do not make the time or effort to reach out to the other parent. Fathers are not included in risk assessments, even when they have been the abuser. Welfare policies marginalize fathers, and parenting classes tend to focus on mothers (Brown et al. 2009).

The literature suggests that the main reason that these fathers are not involved is a system that has not expected or trained child welfare workers to include fathers (Maxwell et al. 2012). Societal expectations are focused on the father's role as financial provider. Unemployment and poverty thus create feelings of failure in fathers, reinforced by being ignored by the child welfare worker. Young fathers are often viewed as "risky" because of their use of drugs and alcohol and high rates of incarceration. They can be seen as deviant, dangerous, irresponsible, and irrelevant (Brown et al. 2009). In one study, only 20 percent of fathers were classified by child welfare workers as potential assets to the family (Strega et al. 2008).

It is not clear whether fathers, as a whole, want to be involved and whether there thus needs to be both willingness to be inclusive and outreach to welcome fathers. A qualitative study provides interesting insights. Asked their perceptions of fatherhood, fathers described their role as "financial provider, nurturer, teacher, and disciplinarian." They expressed commitment to preserving their families (Coakley 2013:630). They evidenced willingness to comply with caseworker demands in order to have their children with them. And they commented on workers' propensity to work with the children's mothers and to provide more services to mothers. As one father said:

> But everybody I talk to basically looks at my wife and hold conversations with my wife when its me,

> you know what I'm saying. I am the one who took the initiative to come here. I took the initiative, swallow my pride and say, hey look I need some help. My wife didn't, it was me. You know, but I mean it's like social services is very female-oriented there. They want to help the female. (Coakley 2013:634)

Caseworkers discussing fathers in focus groups pointed out that mothers may be more familiar with social service systems and more comfortable accepting help, and services may be more oriented toward them. Many fathers have a criminal history or have failed to keep up with child support payments; these fathers may fear that involvement with the child welfare system will jeopardize their ability to manage these parts of their lives. They also thought that child welfare agencies treated fathers more severely than mothers (O'Donnell et al. 2005).

Fathers have difficulty engaging with the agency and in working toward their case plan goals. Those who feel welcomed and respected are likely to work to complete their case plan goals. Fathers want to be involved in their children's lives. They can be an asset to family stability or a risk. In either instance, child welfare workers need to meet them with respect and understanding and include them in service planning.

Outcomes

The basic task of protective services is to see that children are safe. A case that has been opened in protective services because there is risk of maltreatment cannot be closed until that risk is controlled. Whatever factors created risk when the case was opened must have been modified or the factors that created safety must have been strengthened. Outcome is a broader concept, asking not only if the child remains safe over time, but also if the child is better off because of the protective service intervention. It encompasses the dimensions of permanency and well-being. The case we have been following is an example of a positive outcome (box 3.7).

BOX 3.7

The mother: *"I was kind of leery about it [parenting classes] at first, but once we started going it was like yes, this is really helpful."*

And concrete services, offered by another agency in the community, were even more helpful.

The mother: *"She brought out information on ADHD and different ways for treating that. . . . she brought out information on budgeting and kind of went over it. . . . She brought out activities to do with the kids; she brought out zoo passes. . . . A recipe for homemade play dough. Just different things."*

The result of the services? In the words of the parents, the protective service intervention "brought back focus on being a healthy family again. . . . The house is organized and it is easier to deal with the [ADHD] child without all the clutter. . . . We put locks on windows and cupboards; it made me think more about what I am leaving down and putting it up. . . . We take more time with the children, and the children have noticed a difference in how we interact."

When a case is closed in protective services, are the children safe? Have families been strengthened sufficiently that they remain safe? Those are the basic questions asked of protective services. The most frequently used measure in answer to this question of child safety is the rate of re-abuse, usually measured by substantiated reports of abuse or neglect.

About 20 percent of families become reinvolved with the child welfare system; these families, however, use approximately 50 percent of agencies' personnel and resources (Center for Community Partnerships in Child Welfare 2006). Children in these families, repeatedly victimized, are at high risk for symptoms of trauma (Finkelhor, Ormrod, and Turner 2009). Child and Family Services Review data for 2010 show that 5.6 percent of children who had a substantiated report of abuse or neglect in the first part of the year had a second substantiated report within six months. Recurrence was more likely with neglect than with other types

of maltreatment (U.S. Department of Health and Human Services 2012b).

Research has identified consistent risk factors for re-abuse—not unlike the risk factors for initial maltreatment. Poverty, young children in the home, lack of parent education, and young parents are prominent. Substance abuse, domestic violence, and mental health issues were found in higher proportions among those cases that had experienced prior openings (Center for Community Partnerships in Child Welfare 2006). These families have multiple and complex problems and need long-term help; keeping a child welfare case open for a short period of time without ongoing supportive services may set the stage for a re-referral.

The most intensive services are usually directed at families considered at high risk; these may also be the families with the highest risk of re-abuse. Thus, findings that families receiving foster care and other intensive services are more likely to return to protective services may not demonstrate that services are ineffective (Jonson-Reid et al. 2010). More worrisome are the findings of Inkelas and Halfon (1997) that few children had received substantive services while in the system the first time: 81 percent of the children with prior case openings had never progressed beyond an investigation. Inkelas and Halfon speculate that this "recycling" may be a characteristic of cases that "hover" just below a threshold that would warrant intensive services or foster home placement. One hopes that evolving patterns of service delivery will encompass these families.

Critical Issue: Disproportionate Representation of Children of Color in the Child Welfare System

Child protection services must, obviously, be offered in response to the needs of children and their families and be responsive to the customs of the diverse families encountered by the system. However, in 1983 a landmark publication documented the disproportionate percentage of children of color in foster care (Close 1983). The problem is not resolved. A look at the child welfare statistics shows that the percentage of African American and Native American children involved in the system is greater than would be expected, given their percentage in the population (figure 3.3). A disproportionate number are reported to the protective service system, and the reports are more likely to be investigated

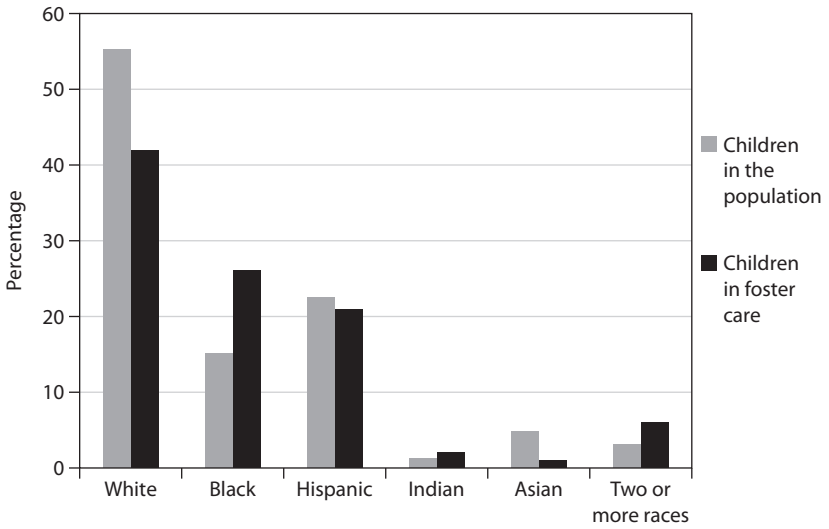

FIGURE 3.3. Children in the population and in foster care by race and ethnic group *Source:* AFCARS 2013 (U.S. Department of Health and Human Services 2013)

and substantiated (Hill 2006). African American and Native American children are more likely to be placed in foster care (U.S. Government Accountability Office 2007:8). In 2011, about 50 percent of the children in out-of-home care were children of color (U.S. Department of Health and Human Services 2012b). Children of color spend a longer time in foster care and are less likely to be reunited with their families or to be adopted (Chibnall et al. 2003:8).

One thing that children and young adults show us over and over is that the best place for children to grow is in their own families. Foster care is a much needed temporary solution when a child cannot remain at home, but it needs to be temporary, and work needs to focus on the child's return to his or her own family. Data on children in foster care make clear that children of color are in foster care in numbers disproportionate to their numbers in the population. Although African American children make up roughly 15 percent of the population, 22 percent of the children in foster care in 2012 were African American. Native American children are 1 percent of the population and almost 2 percent of the foster care population. Hispanic children are about 15 percent of the child population and about 21 percent of the children in foster care. White children and Asian children are underrepresented in foster care (U.S. Department of Health and Human Services 2012b). In the past decade, as the child welfare system became aware of the issue and began to consider remedial action, disproportionality has improved, but it has not disappeared.

The interpretation of these statistics is complex.[8] The possible reasons seem to be (1) more children of color are actually mistreated, thus there are more in the child welfare system, or (2) children of color are more likely to be reported, or (3) reports of maltreatment are treated differently for white children and children of color, and thus, even though reporting is proportionate to need, more African American children and Native American children end up in foster care. An additional factor is poverty; study of the issue almost always finds abuse and neglect associated with poverty.

Incidence of Abuse and Neglect

If the needs of children of color are greater than those of white children, if more children of color are actually mistreated, then the high proportion in the system may be a response to the needs of that population. NIS-4 found that the incidence of maltreatment was higher in African American families than in white families (Sedlak et al. 2010). Though the three prior NIS reports found no statistically significant race differences in the incidence of maltreatment, the NIS-4 has found that African American children are twice as likely as white children to be maltreated, with the difference strongest among neglected children:

> White and Black children differed significantly in their rates of experiencing overall Harm Standard maltreatment during the 2005–2006 NIS-4 study year. An estimated 12.6 per 1,000 White children experienced Harm Standard maltreatment compared to 24.0 per 1,000 Black children. Thus the incidence rate for Black children is nearly 2 times the rate for White children. The rate for Black children was also significantly higher than that for Hispanic children (14.2 per 1000), with Black children 1.7 times more likely to experience Harm Standard maltreatment than Hispanic children. (Sedlak et al. 2010:4-22–4-23)

Numbers of Native American children in this sample were too small to create population estimates.

Prior to 2010, data led to deep concern that there was substantial racism embedded in the child welfare system. Indeed, careful analyses of a series of studies seemed to point to this conclusion (Roberts 2002:47ff.). Then, with the publication of NIS-4 in 2010, the equation changed. Now it seemed that there was indeed more maltreatment, particularly neglect, among African American families. These findings do not, however, negate the need for

careful examination to be sure that the child welfare system is indeed providing the best possible response to the needs of all children. A first step in the examination of this question is an attempt to determine where, in the series of decisions that are made, the disproportionate representation of African American and Native American children begins.

Reports and Substantiation of Reports

Entry to the child welfare system begins with a report of abuse or neglect made by a professional who sees a child and is concerned, or by a neighbor or other citizen. Existing research does not identify a racial bias in reporting, but it is clear that many reports concern families that are poor. African American families tend to be poor, so that even without racial bias, there may be a disproportionate number of reports of African American families. A high proportion of reports of abuse and neglect of children (three fifths in 2011) come from professionals—schools, law enforcement, social services, and medical personnel (U.S. Department of Health and Human Services 2012a). With the exception of schools, these sources are more likely to be in contact with families for whom poverty is an issue and who use public facilities. And, of course, poverty makes it more difficult to buy the resources, such as quality child care, a car, and so forth, which help in providing good care for children, and it interacts with other forces such as drug abuse, involvement in the criminal justice system, domestic violence, teenage pregnancy, and unemployment, which can be factors in child maltreatment. There is also some evidence, primarily coming from medical settings, that families of color are more likely to be reported for child abuse (Hill 2006:18–19). There is not clear support, however, for the hypothesis that the disproportionality can be explained by differential reporting rates.

Not all reports are investigated. Overall, approximately 40 percent of reports are screened out and have no further investigation (U.S. Department of Health and Human Services 2012a). Screening decisions seem to involve a variety of factors, such as age of child, severity of injury, or source of report. Though study results are mixed, most studies suggest that race, interacting with other factors, is related to the rate of investigation (Hill 2006:20). An analysis of NIS-3 data suggested that race alone did not predict whether there would be an investigation, but was a factor when children were emotionally maltreated or physically neglected, when the injury was fatal or serious, when the maltreatment had been recognized by mental health or social service professionals, and when the perpetrator was involved with alcohol or drugs (Sedlak and Schultz 2005:114–115).

Of those reports that are investigated, only 22 percent are substantiated (U.S. Department of Health and Human Services 2012a). A comprehensive review of studies of substantiation identified four key predictors of substantiation: the report was made by a professional, there had been prior reports of maltreatment, the report was for physical abuse rather than neglect, and the family was African American or Hispanic (Zuravin, Orme, and Hegar 1995). Hill (2006) reports that studies done in several different states have found that African American families are overrepresented in rates of substantiation.

Thus, whether due to greater need from a socioeconomic disadvantaged status, because of a greater incidence of child abuse and neglect, or because of bias in the system, African American families enter the child welfare system in greater numbers than their proportion in the population would suggest. The reader will remember that overall, about three fifths of victimized children who receive services remain in their own homes, and about two fifths are placed in foster care.

In-Home Services

The disproportionately high number of children of color in out-of-home care raises questions about the use of services to preserve families

for children. Race has not been a variable extensively examined in the studies of family preservation. Schuerman, Rzepnicki, and Littell (1994), in a large study of family preservation in Illinois, found differences between families in the urban areas, where approximately 90 percent of the sample was African American, and more rural areas, which were predominantly white. Urban families tended to have problems related to child neglect, often due to substance abuse, while more rural families were more likely to be referred due to emotional problems, difficulties with relationships, and child behavior problems. The family preservation program was more successful in reducing the risk of placement for families with marital and emotional problems and less successful in avoiding placement for families with cocaine problems. Thus, the family preservation program was more successful with white families, but the difference could be related to the nature of the presenting issue and only indirectly to the race or ethnicity of the family or to the worker's skill or investment. This interpretation is congruent with that of Rodenborg (2001), who reports that her secondary analysis of the National Study of Protective and Preventive Services data indicates that even if white and African American families receive similar services, those services may be a better match to the needs of the white family than to the needs of the African American family. She notes that less than a quarter of the children in her sample had poverty-related needs met by the child welfare system, while 80 percent of the caretakers needing mental health or behavioral health services received them. The data are provocative, inconclusive, and worthy of serious attention.

Placement in Foster Care

A higher proportion of the African American and Native American children who enter the system because of maltreatment end up in foster care. There is evidence that children from African American, Native American, and, to a lesser extent, Hispanic families are separated from parents and placed in foster care more often than children from white families, even when family characteristics and problems are similar. Data from the National Survey of Child and Adolescent Well-Being (NSCAW) indicate that in 2000, about 16.4 percent of white children, for whom maltreatment was substantiated, were placed in out-of-home-care, while 35.2 percent received services in their own homes (46 percent remained at home with no services). In contrast, while 39 percent of African American children received services in their own homes, 28 percent entered out-of-home care. Latino children were less likely to be removed from their homes (12.5 percent) and more likely to remain in their own homes without services (59 percent). Other case characteristics were similar among the groups (Ortega et al. 2010). This finding is confirmed in other reviews of the literature (Hill 2006).

Once into foster care, families of color have received fewer services, had fewer visits with their children in foster care, and had less contact with their caseworkers (Courtney et al. 1996:107–113). They received fewer concrete services such as housing assistance (U.S. Department of Health and Human Services 1997). Though parents are offered parenting classes and drug and alcohol treatment at rates similar to those for white parents, African American children were less likely to receive services such as psychotherapy and counseling; instead they may be labeled as a "problem child" or "juvenile delinquent" and transferred to more restrictive placement settings (Roberts 2002:22–23).

Kinship foster care has expanded in recent years and may be considered a mark of cultural awareness, exemplifying the appropriate use of the care system of another culture. It is frequently used for African American children and fits the cultural norms of that community (Roberts 2002). However, despite their disadvantaged economic status, kinship foster homes generally receive fewer support services than do regular foster homes. Kin caregivers are less likely than unrelated foster parents to receive

foster parent training, respite care, educational or mental health assessments, individual or group counseling, or tutoring for their children (Hill 2006).

African American children also remain in out-of-home care longer than white children. Courtney et al. (1996), reviewing studies from several states, concluded that African American children were likely to remain in out-of-home care longer than white children. The average stay of all children in foster care in 1990 was seventeen months; African American children had an average stay of twenty-four months (Select Committee on Children, Youth, and Families 1990). Hill, writing fifteen years later, also notes that African American children remain longer in foster care (Hill 2006). Placement stability is another measure of the quality of the out-of-home care experience. Data on placement stability for children of different races are scarce, and results are mixed (Fanshel and Shinn 1978; Zinn et al. 2006; Wulczyn, Chen and Hislop, 2007). Children in kinship care, the placement of many African American children, tend to remain in foster care longer than children in regular foster care, but the placements tend to be more stable (Hegar and Scannapieco 1999). These longer stays in foster care contribute to the larger numbers of African American children in the foster care system, as a child in foster care for three years will be counted in each year.

Reunification with Parents

African American children are reunified with parents in smaller numbers than white children. In a recent and comprehensive study, Hill (2006) found that white children were four times more likely to be reunited than were African American children. Some of this difference is perhaps due to the higher rate of placement of African American children with relatives; children in relative placements are less likely to be reunified. Children were more likely to return to families where families had received services and where the caregiver had job skills and no substance abuse problem (Hill 2006). Lu et al. (2004), comparing rates for African American, Hispanic, and Asian children, also found African American children to be most likely to be placed in foster care and least likely to be reunited. These findings seem consistent with earlier work.

Adoption

Historically, children of color have left the foster care system for adoption at a much slower pace than white children. In 1998, of the 110,000 children waiting for adoption, 56 percent were African American, and 28 percent were white (U.S. Department of Health and Human Services 1999). The pressures of large numbers of children lingering in foster care led to the passage of the Adoption and Safe Families Act (ASFA) in 1997; the problem of African American children spending long periods in foster care, and of large numbers of them waiting for adoptive homes, led to passage of the Multiethnic Placement Act of 1994 (MEPA) and the Interethnic Adoption Provisions Amendment (IEPA) in 1996. These laws encouraged adoption and attempted to remove barriers; they imposed severe penalties on any agency that delayed an adoptive placement to await a race-matched home. MEPA mandated, but did not fund, increased efforts at recruitment of adoptive homes among families of color. By 2011, only 28 percent of the children waiting for adoption were African American, and 40 percent were white (U.S. Department of Health and Human Services 2012b). The proportion of the African American children finding adoptive homes now seems comparable to that of other racial groups; of the children adopted from the public child welfare system, 23 percent were African American, 21 percent Hispanic, and 45 percent white (U.S. Department of Health and Human Services 2012b). Thus, the system seems to be making progress in finding adoptive homes for African American children, though, of course, these are the same children who were not reunified with their parents.

Final Thoughts

Although these many indicators raise questions about inequities in the child welfare system, they do not provide guidance about how to improve child welfare services to erase the differences. Even if there is more maltreatment in the African American community, it seems that a bias against African American families appears early in the decision-making process. This is reinforced with every decision. Worker training to recognize the biases that we all have may be a facet of the solution. Common sense suggests that the education and hiring of more minority child welfare workers would improve service delivery to populations of color, but there has been little conclusive research on the effectiveness of that strategy (Courtney et al. 1996; Lu et al. 2004).

So what can be concluded from these multiple indicators with their mixed messages? It seems that there may be more child maltreatment in the African American community, along with greater poverty. It is probable that changes in the child welfare system cannot erase the disproportionality; larger societal changes to impact poverty are needed. However, changes in the system can certainly ensure that African American children and their families, once identified to the system, receive services of a nature and quality similar to those received by white children. Racial inequities in the provision of services should be of great concern.

It is probable that the disproportionality in numbers in the system exists because there is a disproportionality of need. The social and economic situation of African American families suggests that there is a need for supportive family services—from adequate income maintenance, through child care, and on to health, mental health, and education services. The child welfare system has its responsibility to direct needed services toward this community, both to prevent child maltreatment and to support families in adequate and meaningful ways.

Conclusion

This chapter has reviewed the protective services at the heart of the child welfare agency's mission. Although it can be argued that the community as a whole is responsible for its children, the community has delegated to the child welfare agency the responsibility for seeing that children are safe. This responsibility is the most complex task that social workers undertake. It calls on all the social worker's skills of assessment, of clinical decision making, and of engaging families in working relationships. At the policy level and at the individual case level, tension arises continually between the child's need for the security of his own family and his need for safety from harm, and between the community's responsibility for its children and the family's rights.

The power of the child welfare agency, its use of authority as it investigates and substantiates maltreatment, and its power to remove children from a maltreating home has often created fear and hostility in families. Statistics indicate that substantiation rates are fairly low, and many families that the agency encounters receive no services. The recognition of the prospect for preventing further maltreatment by providing services to more families currently screened out, and of the need for more individualized and appropriate services for families while their children remain in their homes, has given rise to an alternative paradigm for the delivery of protective services. This is a model that recognizes and builds family strengths, engaging the family in assessment of the reported situation and directing family members to community services. Service use is voluntary in this model. Outcome measures of re-reporting for maltreatment indicate that it keeps children as safe as the traditional authoritarian model of protective service, though it has mostly been used with families where risk of maltreatment is deemed low.

In addition to keeping children safe, protective services work to strengthen families. However, some families receive few or no services

even when maltreatment has been substantiated. Other families too often receive the commonly used services familiar to the caseworker, such as parent training, even if those services do not address complex unmet needs. The availability of services varies widely, with fewer services being available in rural areas. Services need to be provided in a culturally competent manner in order to be useful to families. And fathers, often ignored, need to be included in the service provision.

Finally, we have examined a serious problem in child welfare services, the disproportionate representation of children of color in the child welfare system. As the problem is examined, it seems that the disproportionality begins with the initial response by protective services. However, at each decision point, there is evidence that children of color are treated differentially, and as a result are more likely to be separated from their families and to spend more time apart from them. Because we have clear evidence that children grow best in their own families, this is indeed of great concern. It is reassuring that in the ten years since the disproportionality was recognized, it has diminished. The progress needs to continue.

NOTES

1. The National Incidence Study of Child Abuse and Neglect (NIS) was described in the first chapter. Data were obtained from a nationally representative sample of more than 5,600 professionals. They reported whether they had known of a child who had been harmed or was at risk of harm; they also provided information about whether they had reported the incident. There have been four such studies (NIS-1 to NIS-4), published in 1980, 1986, 1993, and 2006.
2. A diagram of the alternative response system and a picture of its integration with the traditional investigatory child welfare system can be found at www.childwelfare.gov/pubs/factsheets/cpwork.pdf. (It is an appendix to the 2013 Children's Bureau publication "How the Child Welfare System Works.")
3. Theodore Stein (1991) has described legal procedures in a way that is very helpful to social workers not familiar with courts.
4. This is very old data and needs to be viewed in that context; nothing more recent on this topic was found. However, the finding makes sense in the current context and is serious.
5. NSCAW data contain additional detail about service receipt. The data paint a somewhat more encouraging picture of service delivery.
6. A moving example of the destruction that this lack of knowledge can cause is contained in Anne Fadiman's anthropological study, *The Spirit Catches You and You Fall Down* (New York: Noonday Press, 1997). One would like to think that there was now more awareness of the responsibility of the dominant culture to understand the immigrant culture—but one is not sure.
7. In Jason DeParle's *American Dream: Three Women, Ten Kids, and a Nation's Drive to End Welfare* (New York: Penguin Books, 2004), the role of the absent fathers of these ten children is described. Particularly vivid are descriptions of visits to the incarcerated fathers.
8. Among the complexities, the reader must be aware that data cited will vary with the date of the study. The most recent data are used when available, but the conclusions of some studies done in the not-too-distant past need to be reported. The reader should not try to make the number of children in foster care in 2001 match the number in 2012—though it is interesting how stable some of these numbers are.

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4

Family Support and Child Well-Being

WITH KAREN TVEDT

Brain scientists tell us that the early years are when critical cognitive development takes place. Social scientists tell us that the investments we make in early childhood programs can have a huge payoff down the road.

—Kathleen Sebelius, Secretary, U.S. Department of Health and Human Services, 2013

The community services that support the functioning of children and families, if the services are properly organized and funded, form a network of support. Indeed, they are sometimes referred to as "the community safety net." This network not only enhances the development of children but also can serve as a primary means of preventing child abuse and neglect.

Many public systems, such as education and health systems, are used by virtually all families and children, and many private institutions, such as religious and recreational programs, have points of contact with most families. A large number of families in contact with the child welfare system are involved in the justice system, and a great many are in need of income maintenance or income supplements, as well as early care and education for their children. Navigating a path among these systems, each with its own policies and procedures, can be daunting. There is always the possibility that a family that needs help but is not fully eligible for services in any system may "fall between the cracks." Families access services at the community level, and it is there that whatever coordination of services exists needs to take place. The great variability in the availability of services needs to be recognized; many communities, particularly in rural areas, do not provide many of these services.

Family support services can be conceptualized as a pyramid-shaped continuum. The services rest on the base of the adequate resources needed by all families. As one ascends the pyramid, the number of families needing the services decreases, and the intensity of the service increases. The middle tiers represent both broader services that assist in building parenting capacity and services targeted to specific problems; these are the services that one hopes will support the family and aid in preventing child abuse and neglect. The top two tiers depict the realm where crisis has occurred in the family, child abuse or neglect is reported, and the child protection system becomes involved. The very top tier, out-of-home care, is the most intensive and least used tier (figure 4.1).

This chapter discusses selected community-based services found toward the pyramid's base: those needed by all families, family support services used by many families, and more intensive services needed by fewer families. There is increasing evidence that these services alter parenting practices, enhance family well-being, and support positive child development. They are also the services that can prevent child abuse and neglect. Investment in the community services that support families is indeed a wise investment.

Programs Accessed by Most Families

All families need adequate income, housing, health care, child care, education, recreational and spiritual programs—the base of the

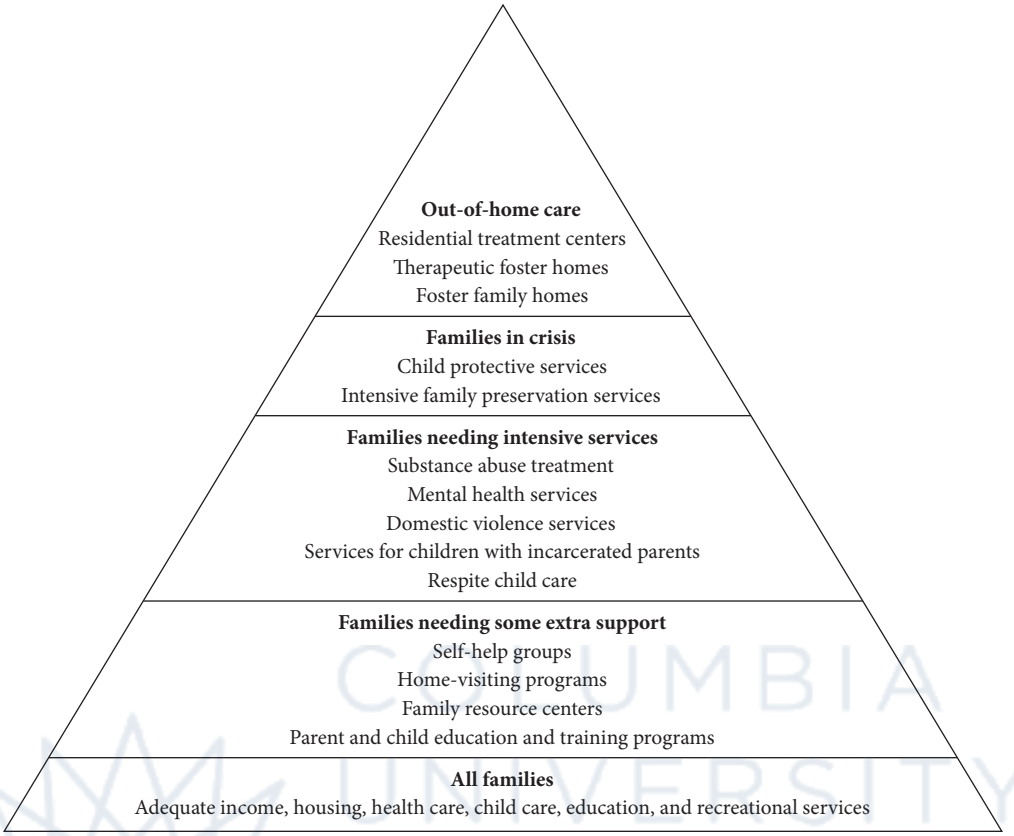

FIGURE 4.1 Continuum of Services

pyramid—in order to raise children successfully. In the United States, we have assumed public responsibility for the education of children. Although many difficulties remain in securing education of equal quality for all children, some of which were noted in chapter 1, education is at least recognized as a developmental service that the state should provide to all children. Health care is emerging as another family support service for which the state has responsibility.

The following sections detail community efforts to meet the needs of families that need some additional help and support if they are to continue to function well. The critical issue of the chapter looks in greater depth at early care and education, which the research described in the preceding chapters is identifying as critical to child development. Together, this mix of programs both supports the healthy development of children and works toward preventing child abuse and neglect.

Income Support

Basic to the stability of a family and to the well-being of its children is income adequate to buy food, shelter, and the basic amenities of living in communities today. One out of every five children in the United States lives in a poor family (Children's Defense Fund 2011). Poverty is a pervasive "risk factor"; it is associated with family problems of child abuse and neglect, crime, substance abuse, family violence, depression, and health problems. It contributes to limited opportunity for children—family instability

and homelessness, school failure and dropout, and involvement in the juvenile justice system. Perhaps most devastating, hunger and the chronic stress of unstable living conditions in very early years impact the ability to learn.

As outlined in chapter 1, the philosophy of income maintenance in the United States is that of providing little enough help that families are encouraged to be self-supporting, while providing employment counseling and child care sufficient to enable mothers with small children to gain full-time employment. Time limits on the duration of income assistance are an added incentive to join the workforce. Ignored are the difficulties of supporting a family on a minimum wage and the difficulties of establishing full-time child care for young children. The unfortunate effects on children's lives are documented. The ultimate cost to the community is great.

Health Care

Every other industrialized nation in the world has universal health coverage. Until the health care reforms of 2012 in the United States, only those over 65 years of age and the very poor were guaranteed coverage through the federal- and state-funded Medicare and Medicaid programs. The reforms in health care enacted in 2012 provide the framework for access to health care by all families. Briefly, these reforms propose that health insurance exchanges be established so that individuals and families can compare health plans and costs, that insurers not be allowed to deny coverage to those with preexisting conditions, and that the federal and state governments subsidize health insurance for those that cannot afford it. Most of these changes took effect in 2014.

The need for this change is evident. Almost 20 percent of our families whose members are under 65 have no medical insurance. Eighty-five percent of them have at least one family member working, usually at a low-wage job that does not provide medical insurance benefits. They do not earn enough to afford insurance. The Child Health Insurance Program (CHIP) has provided health care for children, but not all eligible children are enrolled (Children's Defense Fund 2011). For families without insurance, medical care often consists of treating the presenting symptom but does not provide the diagnostic work and follow-up necessary to manage serious or chronic illness. Although in many communities free or low-cost medical care and prescription drugs can be obtained in neighborhood clinics, which are funded by a mix of federal, state, and local dollars, capacity falls far short of the number of patients seeking help. The number of people seeking care from these clinics has increased.

Health care is available to very poor children and families through Medicaid. The program has made a difference: before Medicaid was enacted in 1966, poor families were dependent on charity, and many went without needed medical care. The advent of Medicaid coincided with a dramatic drop in infant mortality rates and with decreases in death rates from childbirth (72 percent decrease), from influenza and pneumonia (53 percent decrease), from tuberculosis (52 percent decrease), and from diabetes (31 percent decrease; Schorr 1988:125).

States are responsible for setting up their insurance exchanges or deciding to use a federal one and for design of the way in which universal health insurance is offered. There will be many variations, including a focus on prevention that some states seem to be developing. Tracking of changes in health status, similar to what occurred after Medicaid was established, will be important in the analysis of the most effective ways of delivering health services.

Affordable and Safe Housing

The lack of affordable housing was discussed in chapter 1. Unfortunately, there is little to add about social programming to address this problem. The absence of activity in this sphere demonstrates the "philosophical redirection of public policy to eliminate the role of the federal government in housing" (Mulroy and Ewalt 1996:125). More than 1.5 million children live in families

without a home (Aratani 2009). Between 2007 and 2009, as an economic recession took hold, the number of homeless school-age children increased 41 percent, and the number of homeless preschool children increased by 43 percent (Children's Defense Fund 2011).

Current initiatives focus on the use of subsidies and vouchers to help the poor afford private rental housing. The success of this program, of course, depends on the availability of low-rent housing and the willingness of landlords to rent to poor families with children. However, the supply of affordable housing for those with very low incomes is diminishing; it shrank by 13 percent between 1993 and 2003 (Aratani 2009). There are no federal policy initiatives to increase levels of housing subsidy or to ensure that subsidized housing is reserved for the very poor.

Innovative programs in public housing and subsidized housing have shown success in providing stable, safe, and affordable housing (Mulroy and Ewalt 1996). However, there is no vocal constituency to publicize and promote these projects. The resultant transient living and sometimes homelessness is a major problem for families with children, and safe and affordable housing can make the difference between a family that stays together or is reunified on the one hand, and long-term foster care for children on the other.

Early Care and Education

Child care and the associated opportunities for early childhood learning and positive development are the critical issues explored in depth in the final section of this chapter. If parents are expected to join the workforce, as our current societal expectations and our income maintenance policies dictate, someone must care for their children. And care needs to be of high quality. In other developed countries, this is seen as necessary to family support and to optimal child development.

For many years, those working in child development were aware of the importance of the very early years of a child's life, when so much learning takes place. Now, new brain-imaging technologies are discovering the patterns of emotional and cognitive growth during the first years of a child's life, when dendrites and synapses grow rapidly in response to nurturing and environmental stimulation. These technologies also reveal the impediments to growth and long-term development that adverse experiences can produce and explain some of the long-term effects found in the Adverse Childhood Experiences Study (ACES) described in earlier chapters. High-quality child care, with abundant learning opportunities, is important.

Families Needing Some Extra Support

Family support services can, to some extent, be conceptualized as services that have developed to provide help to families that are struggling. Many of these services perform functions that resemble those played in the past by extended families or community organizations, such as religious institutions and neighborhood clubs. They provide needed supports to families in difficulty, including those who have been reported for abuse or neglect. They are also services that help to prevent child abuse and neglect.

Family support programs—with their key principles of empowering and strengthening families, developing parenting skills, and nurturing community connections—fit the political agendas of almost everyone. With their goal of strengthening families, they appeal to the most conservative members of society; with their promise of assistance in obtaining educational, emotional, or more specific resources, they fit liberal philosophies. They are a modern exemplification of the original work of the settlement houses.

Historical Roots of Community-Based Programs

By establishing settlement houses in the late nineteenth century, Jane Addams and others pioneered family support programs and access

to services for community residents. The work of the settlement houses embodied many of the concepts of modern community support programs. They used what is now termed an *ecological model*, recognizing that the lives of families were in many ways affected by the communities in which they lived. Through a combination of political advocacy, classes, political discussion groups, and recreational programs, they worked to improve life for community residents. They empowered participants to create change in their families and communities. They also opened their doors to all members of the community, not just families who had specific problems. The close fit with the key tenets of social work is evident.

The social reform movement of the 1960s gave impetus to the development of the family support programs we know today. Volunteers in Service to America (VISTA) worked in many communities, empowering residents to change their communities to meet their own needs better. Head Start, a comprehensive preschool program for disadvantaged children begun in 1965, was probably the most directly influential family support program begun in that era. "Head Start's developers were the first to design a national education program acknowledging the interrelatedness of health, nutrition, parent involvement, and children's learning" (Allen, Brown, and Finlay 1992:14). Parent-child centers were funded under Head Start to provide low-income parents of infants and toddlers guidance in stimulating early development and to assist families with nutrition, health information, personal and economic problems, and obtaining social services; some of these developed into today's family resource centers.

In the 1980s, concern about the number of teen parents and their difficulties led to the development of programs focused on providing information, support services, and usually child care so that parents could finish high school. Home-visiting programs, with a focus on prevention of child maltreatment through family support and parent education, also expanded in the 1980s, led by Hawaii's Healthy Start program, which began in 1985. Teen parents were often a focus of these programs. The pattern has been one of awareness of a community need, the development of a model program to meet that need, and then the expansion of that program.

The State and Federal Role in Funding and Development

Though states have the primary responsibility for providing for the welfare of children, the federal government provides funding to strengthen these services. Title IV-B of the Social Security Act provides funds through two formal grant programs. This funding gives a more solid base to family support programs: in 2012, funding for the two programs totaled $604 million. A broad range of services designed to support, preserve, and/or reunite children and their families are provided through the Stephanie Tubbs Jones Child Welfare Services Act (CWS), which funds a broad range of child welfare services and requires a state match for funds expended. In 2012, $281 million was available under this program; 10 percent of this was spent for family support services. Funding is also received under the Promoting Safe and Stable Families (PSSF) program, supporting family support, family preservation, time-limited family reunification, and adoption promotion and support. In 2012, states were using 26 percent of these federal dollars for family support services and 24 percent for family preservation (Stoltzfus 2012). Program requirements focus on ensuring the safety of the children served, and beyond this on planning for implementation of services: establishing goals for services and measuring progress toward the goals, coordination of services across the state, and reporting on services provided.

Federal funding became available for home-visiting programs, one type of family support program, as part of the Patient Protection and Affordable Care Act in 2010 (the federal health care reform). The Maternal, Infant, and Early

Childhood Home Visiting (MIECHV) authorizing legislation requires that 75 percent of the funding be spent on program models that have established evidence of effectiveness; there are twelve such models currently identified. To qualify for this funding, the program must include home visiting as the primary service delivery strategy, be offered on a voluntary basis, target pregnant women or children from birth to age 5 years, and focus on families where there is risk to child development. The program must also demonstrate "quantifiable, measurable improvements for the populations participating in the program" (National Governor's Association 2011).

There have also been proposals to allow federal funds allocated for foster care to be spent for family support, and waivers have been given to several states for demonstration projects. As public child welfare begins to expand its focus beyond crisis intervention when relatively serious maltreatment has occurred, these additional funds should encourage this family focus.

However, many family support services are small programs offered by private agencies. Funding for these programs comes from local sources, supplemented by grants from foundations and charitable giving by the community. Funding has been scarce, and most programs report much greater need than they can meet. Many of the family support programs that have focused on the prevention of child abuse and neglect have targeted their services to high-risk families, whereas others have made services available to all families within a limited geographic area.

Family Resource Centers

Family resource centers are as varied as the communities they serve. Located in various places that serve as community hubs—a neighborhood community center, a school district center, a hospital, a church—they offer a variety of educational programs, services, and support. Many have "drop-in" programs, children's play groups, and self-help groups focused on a variety of difficulties. Some have home-visiting programs. Most have close links to other community services and can help families access the services that the family resource center does not provide. In the tradition of the settlement house, empowerment of families so that they are active in advocacy and in facilitating community change is a goal of these centers.

Families who are poor and from groups with little political power often feel helpless about changing community conditions and are suspicious of outside organizations. The process of working with families in Casey Family Program's family resource centers is described as, first, the recruitment of families, which often occurs when children become involved in the children's programs. Outreach to parents follows, with centers working to tailor programs to parents' interests and involving them in making program choices. In the diverse communities of today, fluency in the language of the parents becomes important. As families become comfortable within the center, the goal of preparing them to take leadership in the community emerges (Drisco 2005). This is a process of empowerment familiar to many resource centers.

Describing the services useful to families, Allen and colleagues begin a description of five varied family resource centers:

> Imagine a place . . .
>
> . . . where a young mother can go for support and encouragement when she feels overwhelmed by her responsibilities at home.
>
> . . . where she and her children can drop in for a hot lunch, visit with other mothers while the children play, and get some professional advice about a child's special health needs.
>
> . . . where someone has time to sit and talk with her about her own education goals and help her plan the next step toward reaching them.
>
> . . . where a group of parents can sit and talk with a professional about how to help their children cope with violence in their neighborhood.

> . . . where a parent who has just completed a drug treatment program or had her children returned from foster care can find out about available community resources. (Allen, Brown, and Finlay 1992:5)

Such programs are at the forefront of the integrated services, "one-stop-shopping" models of current child welfare practice, where those agencies that serve similar client groups are often housed together. Note the community outreach in the above program description—such resource centers help with everyday difficulties and are a starting place for work on more complex issues. The description is also reminiscent of the settlement houses.

Home-Visiting Programs

Home-visiting programs reach out to families with young children, sending a nurse or other trained professional to the home to check on the welfare of infants and young children and to offer support in parenting. Their roots are in visiting nurse programs. They focus on the important early years in a child's life and aim to influence parental behavior in order to optimize children's development. Research that shows the importance of very early years to child development and early program evaluations that show positive changes in parenting have made these programs popular; there are now thousands across the country.

States use a mix of federal funds and state revenues to support a range of home-visiting programs, all of which share the overall goals of reducing the incidence of child abuse and neglect, improving school readiness, enhancing prenatal and child health, and encouraging good parenting behaviors and attitudes, as well as long-term goals of family self-sufficiency and reduction in youth crime and delinquency (National Governor's Association 2011:2). There is recent major investment of federal funds through the MIECHV program under the health care reform, with $1.5 billion allocated to support home-visiting programs between 2010 and 2014.

The programs vary in explicit goals and in home visitor qualifications. Some programs target high-risk families; others attempt to serve all families in a geographic area. Engaging families in the use of these programs is a major difficulty: only about half of the families originally targeted receive extensive help. In the past ten years, there has been a vast increase in numbers of randomized trials, and some home-visiting programs have begun to show consistent changes in parent behaviors and improvements in child development. There are many home-visiting models; a federally funded review of home-visiting program effectiveness identified thirty-one models (most being used in multiple sites) that had gathered data and seemed to be having impact in some domains (Avellar et al. 2012). States must spend 75 percent of the federal funds allocated to support home-visiting programs that have demonstrated their effectiveness through rigorous evaluation research.

One of the programs consistently demonstrating effectiveness is the Nurse-Family Partnership. This model is directly derived from the early public health visiting-nurse programs, with visits from registered nurses that begin during pregnancy and continue until a child is 2 years old. Begun in Elmira, New York, in the late 1980s, the program uses frequent visits by registered nurses to focus on improved pregnancy outcomes, parenting skills, and the life course of young mothers. In three sets of studies, each extending over a period of several years, the program has demonstrated success in strengthening family life, having significant effects on abuse and neglect, children's behavioral development, mothers' economic well-being, and the spacing of children. Children also fared better in the visited families, with less consumption of drugs and alcohol and lower arrest rates as 15-year-olds. Most of the positive effects of the program were concentrated among the poor, unmarried subgroup of the sample (Olds, Hill, and Rumsey 1998). Expansion of the program began in 1999; there are now more than one hundred sites nationwide, and

four states have statewide initiatives (Howard and Brooks-Gunn 2009). A cost-benefit analysis of the Nurse-Family Partnership found that each dollar invested yielded $5.70 when a high-risk population was being served, $1.26 with a lower-risk population (National Governor's Association 2011:3).

Another extensive home-visiting program is Healthy Families America (HFA), a nationwide support program modeled on Hawaii's Healthy Start. Begun in 1975 in a single community on Oahu, Healthy Start gradually expanded in Hawaii and was in 1992 adopted as a promising model by Prevent Child Abuse America (then known as the National Committee to Prevent Child Abuse). It is now called Healthy Families America, has been implemented in more than three hundred culturally and geographically diverse communities, and has a presence in forty-four states (Prevent Child Abuse America 2013).

In this model, all families are screened soon after a child's birth, and services are offered to all families deemed to be at risk for child abuse or neglect. Participation is voluntary. Although they vary in their outreach strategies and specific goals, all the programs deliver services of sufficient intensity and duration to assist families during the child's early years—services can continue until a child is 5 years old. The home visitors are trained paraprofessionals with varied academic backgrounds. Data indicate that the programs seem to be meeting the goal of preventing harsh discipline and promoting positive parent-child interaction. Results concerning the prevention of depression and parenting stress are mixed (Howard and Brooks-Gunn 2009). In 2011, Healthy Families America was designated by the Department of Health and Human Services as a proven home-visiting model.

Healthy Families America has a dual commitment: system reform and development of community capacity to support families on the one hand, and the provision of direct services to families on the other. Most effort has gone into the development of the individual home-visiting programs. None of the programs has provided access to support services for more than 20 percent of the community's newborns and their parents (Daro and Harding 1999:168). Without the development of supporting community services, the impact of the home visitor is limited.

Home-visiting efforts, though publicized as programs to prevent child abuse and neglect, are not well integrated into existing child welfare response systems. Nor, despite their origins in nurse home visiting, have they become an integral component of public health care systems. Nevertheless, evaluations show success in developing positive parenting attitudes, the quality of the home environment, and child development, and, in the Nurse-Family Partnerships, improved child and family outcomes over a period of fifteen years. The intervention is relatively low-cost, and results are promising. The new federal funding stream should encourage the development of these programs, coordination of their work, and their rigorous assessment.

A federal Healthy Start program, using the same principles and models of service, began in 1991 under the auspices of the Department of Maternal and Child Health; by 2010, 104 Healthy Start grants had established programs in 38 states. The goal of this program is to reduce racial and ethnic disparities in birth outcomes in high-risk communities.

Parent-Training Programs

Parent-training programs are similar in their goals to home-visiting programs. These generally are targeted at families with children of 3 years or older, and often child behavior problems are what bring families into parent training. Parent training is primarily a cognitive approach: the teaching of parenting skills. Usually, this takes place in a group setting, though some parent-training programs have options such as one-to-one instruction in the parents' homes. Community-based parent-training

programs are often found in school and public health settings, where there are groups of young parents-to-be or of parents naturally assembled. Because all parents have some doubts and difficulties while raising children, parenting workshops are offered throughout the community to parents of all socioeconomic backgrounds.

There is probably no service more frequently purchased by child welfare agencies than parent training.[1] One of the causes of maltreatment is lack of knowledge about child development and about what children can do at various ages. Parent-training programs are an excellent vehicle for conveying this knowledge. Another cause of abuse is persistent child misbehavior; parent-training programs are useful in teaching techniques of behavior management. It is also expected that participation in a parent-training group will increase awareness of others' needs and thus increase family support and cohesion. Enhancement of self-esteem and general improvement of child-rearing skills are hoped-for outcomes. In addition, parents find support in meeting with other parents and discussing mutual difficulties and solutions.

There are many parent-training curricula and approaches to curriculum delivery. Among the parent-training programs, the Incredible Years Training Series has received some attention recently; a description of it provides a good example of a parent-training program. As reported by Webster-Stratton (2000), the Incredible Years Parents, Teachers, and Children Training Series uses group discussion, videotape modeling, and rehearsal of intervention techniques to assist parents of children aged 2 to 10 who have conduct problems. Based on cognitive social-learning theory, it teaches reinforcement skills and nonviolent discipline techniques. The primary goal is to reduce these conduct problems while increasing children's social, emotional, and academic competence; improving parental competence and strengthening families are also goals. The program can also be used to help teachers learn techniques for managing classrooms.

Evaluation of the Incredible Years program has been unusually rigorous. A series of studies, using randomly assigned control group designs, have consistently shown positive gains for participating parents across different socioeconomic groups. One study with a one-year follow-up demonstrated that gains are maintained. Another, randomized study was conducted to determine which component of the program was most effective. All proved effective; a self-administered video component alone was the least costly and produced changes comparable to those of group therapy, but was not as well liked by participants (Webster-Stratton 2000).

Work is beginning to identify common elements of successful programs. As would be expected, the best success occurs when parents and trainer share goals, and parents are actively engaged in the training. Frequency of meeting and duration of training are associated with greater goal achievement. A strong theoretical base and instruction in specific behavioral parenting techniques is a common thread among successful programs. Finally, the programs that seem to have the most success, though they use a variety of training approaches, can tailor those approaches to the specific needs of a family. However, rigorous evaluations of many of these programs have not yet occurred. The next step should be the establishing of clinical trials. Because of funding and existing structure, this may be most readily done in child welfare settings (Barth 2009).

It is worth noting that for the deeply troubled families often served in child protective services, parent training may provide useful knowledge, but the capacity to use this knowledge is not necessarily developed by these cognitively based programs. Nevertheless, parent-training programs are a valuable tool and a great help to many families struggling with the difficulties of parenting.

Self-Help Groups

Self-help groups have become popular in American culture, perhaps another manifestation of

American independence and individualism. They are common in substance abuse treatment; Alcoholics Anonymous is perhaps the best known. Those for parenting often address issues related to children with particular characteristics: transracially adopted children, children adopted when older, foster children, children with particular medical problems, and children with behavioral disturbances.

Parents Anonymous is one of the best known self-help organizations. Its philosophy embodies the values of family empowerment and professional guidance based on recognition of family strengths that are the hallmark of the best child welfare services. Founded by a parent in 1969, it is the oldest of the child abuse prevention organizations. Each year, more than 100,000 parents come together in Parents Anonymous groups "to learn new skills, transform their attitudes and behaviors, and create long-term positive changes in their lives" (Rafael and Pion-Berlin 1999:1). With a program philosophy of shared leadership, each group has a parent leader and a professionally trained facilitator. Children's groups run simultaneously in some settings; in others, child care is provided. Many state and local organizations also run 24-hour telephone help lines for parents seeking immediate help with their responses to their children. There is a strong public awareness component to the program, including outreach to potential participants.

Parents join Parents Anonymous because they want to change their behavior toward their children and because they seek help, information, and support in managing specific issues facing their families. Sometimes attendance is mandated by a court order or child protective services agreement. The groups reach across gender and racial lines. Very little data is available about the characteristics of parents using this service; there is some informality about the open, parent-led meetings, and confidentiality is respected. A sample drawn from a nationwide study showed participants to be mostly women (91 percent), low income, about half African American and half white. Half had a child with special needs in the home, and half had a history of physical or mental health needs. Half were single parents (Polinsky et al. 2010). A 1999 study painted a slightly different picture; at that time, about a third of the participants were male. Fifty-one percent of the participants were white; 22 percent Hispanic, 21 percent African American, 5 percent American Indian, and 1 percent Asian or Pacific Islander (Rafael and Pion-Berlin 1999:4). The Parents Anonymous website (www.parentsanonymous.org) has information directed to both men and women and some material in languages other than English, suggesting that these groups continue to be heterogeneous.

To join a Parents Anonymous group takes courage; it involves the recognition that one's own behavior needs to be changed. Parents at risk of involvement in the child welfare system are often stigmatized and often socially isolated. The organization's ability to reach out successfully across racial groups speaks to its capacity for developing culturally appropriate services when parents themselves are in leadership positions. Cameron and Birnie-Lefcovitch (2000), describing a parent mutual aid program in child welfare, report that "members expressed a pride, a sense of ownership and protectiveness towards the program, and an enthusiasm about their involvement that is hard to match in programs designed and delivered solely by professionals" (p. 435).

Each group has a parent leader and a professional leader. The professionals come from many different disciplines. Maintaining true joint leadership can be difficult for professionals, particularly those who have been working in child welfare. The shared decision making differs from their usual mode of working. Some find it difficult to accept that parents are as competent as professionals to assess the needs of children and to plan meetings that will help other parents meet those needs. Specific training and supervision in the shared leadership role may be necessary.

The literature on self-help groups suggests that the support of other parents faced with similar situations can lead to positive changes in self-esteem and attitudes toward parenting, as well as positive changes in perceived social support (Cameron and Birnie-Lefcovitch 2000). A recent study of changes that occurred in the first six months of participation in Parents Anonymous programs was encouraging, showing decreased risk factors and improved protective factors and decreased psychological aggression, with the biggest changes occurring for those at greatest risk at entry into the program (Polinsky et al. 2010). Recent interest in training and certification of parent leaders is expected, according to the website, to lead to more capacity to evaluate program outcomes.

Families Needing Intensive Services

A high proportion of the families who enter the child welfare system because their children need protective services are involved in the criminal justice system and/or have problems of substance abuse. Some have mental or physical health needs, many are overwhelmed by the demands of children with physical or behavioral difficulties, and family violence is common among them. These families are in need of specialized assistance if they are to raise their children successfully.

Substance Abuse Treatment

Substance abuse is a pervasive problem and a common contributing factor in placement of children in foster care. It occurs in about 11 to 14 percent of investigated families in contact with the child welfare system, and from 50 to 79 percent of children taken into foster care (Testa and Smith 2009). Most children in substance-abusing families live with their parents throughout their childhood; 11 percent of children in the United States live with at least one parent who is either an alcoholic or in need of treatment for abusing illegal drugs (U.S. Department of Health and Human Services 1999:1–2). Although the child welfare system commonly uses the "solution" of placing children in foster care until the parent is "clean and sober," it is perhaps more realistic to focus on careful assessment of parenting capacity despite substance use and on the type of support available to parents that might enable them to care for their children, even if the parents are not completely successful in ending their use of alcohol or drugs.

Children seldom enter the child welfare system because of parental substance abuse alone. Most families in the child welfare system have multiple problems, and substance abuse often coexists with other problems such as mental health, poverty, inadequate housing, or domestic violence. This complex set of difficulties prevents effective parenting. An early task of the child welfare worker is to distinguish the extent to which substance abuse is the reason for the maltreatment. A comprehensive approach to the family problems may be more effective (Testa and Smith 2009). Substance abuse treatment programs are moving toward new models that use case managers to help families address their multiple problems.

Child welfare workers have not been adept at linking families to substance abuse treatment. One study found the services most commonly offered substance-abusing parents to be employment training (82 percent), substance abuse treatment (70 percent), parent training (50 percent), psychological assessment (22 percent), and household management services (22 percent; U.S. Department of Health and Human Services 1999). Child welfare agencies face difficulties in helping families receive substance abuse treatment; often, there are too few treatment resources or clients are dependent on limited insurance coverage to pay for treatment (Child Welfare Information Gateway 2009). Family treatment drug courts are an expanding program model designed to assist families involved with the child welfare system in obtaining prompt treatment and in staying with that treatment; they have been shown to be effective in facilitating positive child welfare outcomes (Green et al. 2007).

Increasingly, state systems are identifying substance-exposed infants, many of who are placed in foster care from the hospital. The impact of prenatal exposure to alcohol or, to a lesser extent, drugs is very serious, leading to a variety of behavioral and cognitive problems. The quality of the postnatal environment is critical in helping the child overcome these handicaps. Parent-child interaction needs encouragement and support, as well as monitoring, and a parent who has exposed her fetus to drugs or alcohol cannot be assumed to be ready to parent. Child welfare workers are often tempted to use foster care to ensure high-quality care; however, if an infant is placed in foster care, early mother-infant bonding is placed at risk. And if the mother is not able to access treatment quickly, it may be a long time before mother and child are allowed to be together again. Careful evaluation of the situation is needed to be sure that foster care is necessary.

Children from substance-abusing families are more likely to enter foster care than are children from families with other problems (U.S. Department of Health and Human Services 1999). The timelines of planning are relatively short once a child is in foster care. Because children's development proceeds at a rapid pace, the Adoption and Safe Families Act (ASFA) mandates beginning action to achieve a permanent home when a child has been in foster care for fifteen of the past twenty-two months. Waiting lists for many treatment programs are long, particularly for those designed to meet the needs of women with children. Substance abuse is a chronic illness. Most of those who succeed in conquering an addiction do so over a period of years, during which they are counseled to live lives as free from stress as possible, and usually after one or more relapses. Less than one third of substance abuse treatment clients achieve sustained abstinence after their first attempt at recovery. Another third eventually achieve long-term recovery but only after repeated episodes of relapse (U.S. Department of Health and Human Services 1999). Increasingly, practitioners and policy makers recognize the importance of accommodating these recovery patterns. The dilemma is clear.

The effectiveness of substance abuse treatment in permitting parents to resume custody of their children is open to question. When the results of a substance abuse treatment program in Illinois were analyzed, with a sample size of 724 substance-abusing families, the authors concluded that only in those families where substance abuse is the only problem (8 percent) will substance abuse treatment alone have much impact. Reunification rates were highest among those who completed mental health treatment (41 percent) and those who solved their housing problems (12 percent). The authors concluded that client progress in these co-occurring problem areas is needed, in addition to completing substance abuse treatment (Marsh et al. 2006). A study in Oregon found that the more quickly a mother entered substance abuse treatment, and the more time spent in treatment, the sooner the children returned from foster care (Green, Rockhill, and Furrer 2007). Again, the importance of work across treatment boundaries is emphasized.

Horn (1994) writes that the current model of child welfare, in which a family is supposed to be "fixed" during a child's brief stay in foster care, will not work when substance abuse is the underlying problem causing child maltreatment; rather, a new model is needed. Adoption will be appropriate for some children. However, when a child does go home, increased use of home visitation and protective service monitoring will also be needed, and cases that are open for a long time should not be considered to have poor outcomes. He also notes the need for increased tolerance of repeated episodes of foster care as parents relapse. The use of relatives for foster care is, he suggests, the best way to ensure that children will return to the same foster home each time foster care is needed. Foley (1994) adds that for some of these

children, long-term foster care will provide the greatest stability and should be an acceptable outcome, an idea that has not been endorsed by policy makers.

Mental Health Services

Mental health services can be even more difficult to access because they are scarce and often not well covered by insurance plans. However, substance abuse and mental illness present similar issues as individuals often become stabilized, only to destabilize a few months later. Both problems require specialized treatment, long-term planning, and continued supportive services.

Perhaps the most difficult and fundamental aspect of the interaction between mental health and child welfare is the assessment of the degree of threat to the child's well-being posed by the illness and of the probability that the parent will have periods of reasonable stability that are sufficient in length for raising a child.

In the case vignette of box 4.1, the difficulties of assessing mental health status and deciding on appropriate action are compounded by cultural differences.

BOX 4.1

Among the families we know is a Vietnamese single parent. Ms. V. is quite alone; she left Vietnam among the boat people and after time in a refugee camp came to the United States as an unaccompanied minor. She has four young children, the oldest 8. Each has a different father, and none of the fathers remains in contact with her. She came to the attention of protective services when she responded to neighbor complaints about her children's behavior by threatening to kill herself and her children. She was also observed chasing her children with a knife, threatening to kill them for misbehavior. This situation raised many questions for the protective service worker.

Is her mental health status such that she is likely to carry out her threats? Or is she expressing a lesser degree of despair in a way more congruent with her culture than with mainstream American culture? Can she be referred to appropriate diagnostic and treatment services and receive them quickly so that decisions can be made about the necessity of placing her children? Can she access community mental health services to sustain her functioning, so that if the children must be placed to ensure their safety, the placement will be brief? Or if the mental illness is serious and pervasive, will it prevent her caring for her children for a long period of time to the extent that an alternative family, perhaps an adoptive family, should be considered?

These are the types of questions that weigh on child welfare workers. It may not be easy to find answers.

Community mental health services have been chronically underfunded. With the deinstitutionalization of the mentally ill in the 1960s came the promise to provide mental health services in the community. Adequate funding for these services never materialized. Adults with psychiatric disorders are as likely as anyone else to be parents (Hinden et al. 2005). Mental health issues often interfere with parenting practices; researchers estimate that up to 70 percent of parents involved with child welfare services have a mental health problem (Marsh et al. 2006). With services in short supply, both parents and children who need mental health assessments or treatment may be forced to endure long waiting periods or be unable to access services at all. Again, delayed access to services for parents, if the children do have to enter foster care, can conflict with the short timelines for planning for children.

There are many mental health problems that interfere with parenting. One that has received considerable attention is depression. Jane Knitzer (2001) writes of women who are subjected to substance abuse, domestic violence, and depression, a commonly linked trio of difficulties. There is substantial evidence that maternal depression is linked to the development of problems with emotional regulation and behavior in children and evidence that as depression lifts, parenting stress decreases

and nurturance increases. One of the effects of completion of parent-training programs is the lifting of depression (Barth 2009).

Families in which a parent has a mental health problem face multiple stressors. Disruptions occur when a parent faces a period of psychiatric hospitalization. Difficulties with employment lead to loss of income, problems with housing, and the array of problems that attend poverty. Mentally ill parents are seen as unable to parent children; loss of custody of children is common and has been estimated to be as high as 80 percent (Hinden et al. 2005). The child welfare worker can become a threat rather than a helper. Courts often mandate that parents complete certain services to regain custody of their child; parents do not always understand why these services are needed. Completing the services required can become very difficult; parents list transportation, financial limitations, restrictions on program eligibility, and the caseworker's lack of understanding of the family needs as obstacles (Estefan et al. 2012). Providers of services do not coordinate their program demands; it is not uncommon for a parent to be required to be in two different places at the same time. Child welfare caseworkers can make it more likely that parents will engage in services by actively assisting parents in completing applications and scheduling and attending appointments (Bunger, Chuang, and McBeath 2012).

Children also need mental health services. The data now available from the National Survey of Child and Adolescent Well-Being (NSCAW) indicate that though gaps between service needs and provision persist in this, as in other domains, "being reported to the child welfare system for suspected maltreatment dramatically increases the proportion of children receiving some type of mental health services" (Horwitz, Hurlburt, and Zhang 2010:325). The increase is greatest for those children receiving services within the child welfare system.

There is a developing model in child welfare of family-centered service provision. This is a strength-based approach, demanding family involvement in assessing needs and planning services. One model of integrated services for families with multiple problems offers promise in allowing families with a mentally ill parent to retain custody of children. The elements a program such as this would have to have to be successful have been identified as family case management, 24-hour crisis services, access to flexible funds to meet varied treatment needs and varied concrete needs, and liaison and advocacy for the family (Hinden et al. 2005). Again, as in the discussion of substance abuse, if these families are to raise their children, long-term community involvement will be necessary, and episodes of foster care may be needed.

Family Violence

When writers examine families connected to the child welfare system that have coexisting problems, the trio of problems is often substance abuse, mental health issues, and family violence. Family violence is considered a form of child maltreatment by child welfare workers, though more recent work has recast family violence as potentially harmful but not necessarily child maltreatment (Edelson, Gassman-Pines, and Hill 2006). It has been discussed in earlier chapters as a concern of protective services. However, it can also be a problem for families who never come to the attention of the child welfare system, and the community response to and support of these families is important.

Because most victims of family violence are women, intervention methods that encourage women to protect themselves and their children have been developed within a feminist framework. The goal is to empower the victim so that she can either leave the abuser or create a system to protect herself and her children. Shelter services, transitional housing, legal advice, advocacy, and counseling all are part of this complex of services. Increasingly, family violence results in involvement with the criminal justice system and sometimes in the

incarceration of the offender. Effectiveness of services, for any of the members of the family, has yet to be demonstrated (Friend, Shlonsky, and Lambert 2008).

The impact of family violence on children in the home is not clear. Early work demonstrated the link between family violence and child abuse and initiated the involvement of child protection in family violence situations (Edelson 1999). Later research has examined parenting, particularly mothering, in violent families more extensively, and a more nuanced picture is emerging. Data from a Canadian study, based on a national sample, suggest that mothers may compensate for the stress in the home by particularly careful nurture of the children (Letourneau, Fedick, and Willms 2007). Using a national probability sample in the United States, researchers discovered the varied patterns of mothering practices. Comparisons of mothering among mothers who never experienced family violence, those who were currently involved in family violence, and those who had previously been in violent family situations revealed few differences, with those for whom the violence was in the past apparently doing the best mothering (Casanueva et al. 2008). Careful assessment of parenting capacity is obviously needed, with tailoring of services to meet any deficits discovered. But any assumption that women involved in violent family situations are poor parents is not warranted.

Child welfare services, when they intervene to protect children, can re-victimize a mother, who is implicitly accused of not protecting her children. If space is not available in a shelter (there are often waiting lists), the children may be removed from the mother while she waits for placement. This philosophical conflict has only begun to be recognized. Domestic violence services and child welfare services have started to develop protocols so that they can together serve these troubled families. These protocols emphasize assessment of any threat to the child and, if the risk to the child is considered low, referral to community-based agencies that will work with the entire family. Alternative response systems in protective services may be useful in furthering the cooperation of these two systems.

Support for Incarcerated Mothers

Parents in the criminal justice system face great difficulties in developing or retaining bonds with their children: because mothers are usually the primary caretakers of children, this is of particular concern when they go to prison. The number of female prisoners has increased almost ninefold in recent years, from 11,212 in 1977 to 96,125 in 2004 (James and Harrison 2005). More than two thirds of these women have children. While their mothers are incarcerated, the children live with their fathers (about 20 percent), with grandparents (about 50 percent), with other relatives (about 20 percent), in foster care (about 8 percent), or with friends or in other arrangements (Young and Smith 2000:131).

Poverty is often a problem for relatives fostering children. Income may be supplemented through Temporary Assistance for Needy Families (TANF) grants. Higher subsidies, without time limits, are available if these homes become kinship foster homes. However, some families are reluctant to go that route because it means they must share decision-making responsibility for the child with the state child welfare agency.

When children are in formal foster care, the public child welfare agency assumes responsibility for overseeing their care and planning for their future. Most mothers plan to reunite with their children after incarceration. However, if sentences are long and the children young, child welfare agencies may consider the benefits to the child of placement in an alternative permanent home. To participate in this planning, incarcerated mothers must be in contact with the caseworker, take part in the discussion of case plans, and be notified of and able to attend each case review (Beckerman 1994). Given the

strictures of prison life, ensuring that mothers have this access requires that child welfare workers be energetic and organized.

Another more subtle concern for incarcerated mothers is how they can develop and maintain a strong attachment to their children and work on their parenting skills so that when they are discharged, they will be good parents. That prisons are often located in remote sites and visitation strictly monitored and often uncomfortable for the visitors can hinder this process.[2] However, scattered programs throughout the prison system attempt to bring children into the lives of incarcerated parents in ways that are as natural as possible and promote parent-child interaction. A small number of progressive prison systems are beginning to develop residential wings in which infants and very young children can remain with, and be cared for by, their mothers. It is a wonderful opportunity for observing mother-child interaction, teaching parenting skills, and supporting the growth of a new family. It is also a difficult program to introduce into the culture of the prison system.

Unfortunately, the experience of the woman described in box 4.2 is more typical.

BOX 4.2

The young mother was in prison when her child was born. She had the baby with her for the twenty-four hours that both remained in the hospital. Then the child was placed in foster care—in this case not with relatives but in a home the mother was unfamiliar with. There was a family planning meeting about the future of the child. The mother was informed of the date and time of the meeting, but the caseworker did not explain its purpose. The court did not request her presence. No one requested transportation. Nobody thought of modern technology such as a speakerphone. Thus she did not attend.

This mother will be released from prison within a year or two—most mothers emerge from prison within a relatively short period of time. Will she have lost her parental rights because she has had no opportunity to demonstrate her ability to parent? If she retains the right to raise the child, how will she and her child bond when there has been no opportunity for interaction? These are the difficult questions that highlight the need for closer cooperation between the child welfare system and the corrections system.

Though concern in the child welfare system focuses on mothers because they are commonly the principal caretakers of children, many of the same issues are part of helping fathers remain engaged with their children during long incarcerations.

Respite Care

The discussion of respite care could appear in any of several chapters in this book, for respite care is important to any family whose coping capacities are stretched by caring for children, whether they are birth families, foster families, or adoptive families. It can take place in a family or a group setting. The availability of respite services varies greatly. Considering that probably the most common use of respite care is to prevent the separation of children and parents, this chapter seems the most appropriate for its discussion.

Not too long ago, children with severe developmental delays and physical disabilities were cared for in institutions. As it came to be recognized that these youngsters had better opportunities to develop to their full capacity within the community, more and more families kept them at home. Institutions that had given lifetime care to these youngsters were gradually closed, as were the institutions that had served the mentally ill. In all spheres of care for people with disabilities, there was a movement to get people out of the isolation of institutions and to expose them to the opportunities of community life.

The development of respite services accompanied the deinstitutionalization movement. As parents began to care for children with disabilities in their homes, the need emerged for occasional relief from the extensive demands of their care. Respite care can be critical in

enabling a birth family to continue to care for a child. It can be critical too in avoiding the need to remove a child from one foster home to another. Families who have adopted children with complex needs and severe behavioral problems find respite care invaluable. The type of care used for respite will vary with the needs of the parents and child; the goal is to provide relief to the primary family so that continuity of care can be maintained for the child.

Early sources of funding were Medicaid waivers, in individual cases of families caring for a physically disabled child, and through the Child and Adolescent Service System Project, which provided money to states for the development of services to children with emotional handicaps. In the early stages funding was, however, uncertain. In 1988, the financial base became more stable when federal funding was provided under the Temporary Care for Children with Disabilities and Crisis Nurseries Act of 1986 (as amended). Under the provisions of this act, grants are awarded for the development of programs to support families of children who are at risk for abuse or neglect or who have disabilities. Various re-namings and consolidations of the act have occurred since, each increasing the collaboration among community programs to support families. The latest consolidations emphasize collaboration among family preservation efforts, family resource centers, and respite care providers.

As broadly defined, respite care is used by almost all parents in the form of school or child care, after-school programs, summer camps, or just a grandmother or babysitter coming in for an afternoon. Children with special medical or behavioral needs can be very challenging to care for, however, and parents have difficulty finding neighborhood services with the appropriate expertise.

Respite care can take the form of group care of children, usually coupled with interventions that teach and support positive parent-child interactions. Crisis nurseries emerged early in the respite care movement to provide day-care relief for families of children with disabilities. Their larger role has been in the prevention of abuse and neglect: the observed interaction of parents and children in the nursery setting offers opportunity for assistance in the development of parenting skills. The example of box 4.3 illustrates the positive impact that respite can have.

BOX 4.3

Ms. W. was a single mother with three young children. The oldest, a 4-year-old, was a particularly trying little boy. He was very active and did not seem responsive to Ms. W.'s disciplinary attempts. More and more she found herself yelling at him and hitting him in frustration. A visiting nurse, there to help with the youngest (very new) member of the family, suggested a relief nursery.

A plan was formed. The 4-year-old went to the relief nursery five afternoons a week. Twice a week, Ms. W. stayed with him for an hour, and staff members watched her interact with him and made suggestions to enhance parenting skills. But, most important, Ms. W. had time without him, to get her house in order, to tend to her younger children, and even sometimes to nap while they napped. The relief from the constant and challenging care of this boy made a great difference in Ms. W.'s patience and parenting capacity. The possibility of abuse, and possibly even of an out-of-home placement, disappeared.

Family respite care is usually planned on an individual basis; that is, a single family becomes the respite care provider for a particular child. The discontinuity occasioned by respite care is not ideal for children and is minimized if the same family is used each time a respite is needed. Often, a respite family receives general training in meeting the child's special needs, but the provider is also encouraged to follow the instructions of the parents and to attempt to maintain continuity for the child between home and respite. Communication between the two families is vital, and often the caseworker assumes the role of facilitating that communication. This type of respite care is illustrated in box 4.4.

BOX 4.4

The M. family had taken in Mr. M.'s sister's new baby as a foster child eight years ago. They had comforted her incessant crying and held her and talked to her as she grew and had grown very attached to her. Sadly, they recognized that she was very slow in mastering developmental tasks. Even more sadly, they recognized that her abilities to reason and to manage her emotions had been affected by her mother's drinking before she was born. Nevertheless, when it became apparent that her mother was not going to be able to make a home for her, the M.s decided to adopt the child. By the time she was 8 years old they were exhausted, their marriage was strained, and their older children were clamoring for some time to do things together without the constant distraction of a constantly-in-trouble sister. Mr. and Mrs. M. began to consider the possibility of another family for the girl.

A respite foster home proved a better answer. The M.s sought help from the agency that had handled their foster parenting and adoption and learned about the possibility of respite care. Interviews and observations enabled the worker to get to know their daughter and the methods they used to manage her behavior. The foster home that was selected had received training as a respite home, emphasizing communication with the child's own family and commitment to managing behavior as the family did. The daughter went to the respite home for one weekend a month.

Once she got to know the family, the child rather enjoyed the change of pace and different activities provided. She seemed content to go and content to return home—though of course she tried to tell each family what the other one let her do. That was when communication between families became important. And the M.s greatly enjoyed a weekend a month when they could focus on themselves and their older children and do the things that cannot be done with an active 8-year-old . . . though sometimes they missed her.

Respite care is beginning to assume its place in the continuum of services for children with special needs, whether they are in their own homes or in foster or adoptive families. The most important point about respite care is that it is always viewed as temporary and focused on enhancing and stabilizing the parent-child relationship.

Critical Issue: Early Care and Education

In recent years, advances in neuroscience, research about the benefits of early intervention, and knowledge about the long-term effects of poverty and stress on young children have highlighted early care and education as a public policy issue of importance. Combined with the changing labor market, increased numbers of working parents, and the shift in welfare policy from economic maintenance to work for low-income families, early care and education has emerged as a critical support to most families with young children. Increasingly, quality early care and education support a broad range of public policy goals including family economic self-sufficiency, child health and well-being, school readiness, economic productivity, and our collective future. For low-income and at-risk families especially, early care and education offer largely untapped potential in supporting parents, child development, and early intervention. Recognizing that young children need care that supports their development, in this section we generally use the term *early care and education* rather than *day care* or *child care*, as the latter two may be perceived as custodial in nature.

Unlike most other modern industrialized countries, attitudes about the appropriate role of mothers and individual family responsibility in the United States have limited our collective involvement in early care and education. To the extent that a system of early care and education exists, it developed primarily as a privately purchased service, dependent on market forces and what parents could afford. While federal and state governments are showing renewed interest in ways to increase the availability of high-quality early care and education services, government involvement has historically been limited to minimum health

and safety requirements for child care providers, subsidies to enable low-income working families to access the child care market, and preschool services for low-income children and their families.

A Historical Perspective: A Mother's Place Is in the Home?

Early care and education has always been a need when economic hardship forced both parents to work or when a single parent was forced to support the family. Records of the orphanages of the 1800s document the admittance of children because a single parent needed child care so that employment would be possible (McCausland 1976). In the factory conditions of the nineteenth century, both women and children worked long hours under dangerous conditions. Older neighborhood women sometimes provided care for children too young to work. And because so many young girls were the caretakers of younger siblings, settlement houses formed "little mother groups" to teach these girls how to care for their siblings (Nasaw 1985). Infant schools and day nurseries first emerged in Europe and then in the United States with the dual purpose of influencing young children and freeing parents to work (Fein and Clarke-Stewart 1973; Steinfels 1973; Schorr 1974).

Within the middle and upper classes, the cults of "motherhood and domesticity" evolved during the 1800s and early 1900s. Gordon argues that early social workers viewed women's involvement with home and family as critical to women, children, and the social order (Gordon 1973). This view of the role of women emerged along with the notion male workers should earn "family wages," an ideal that did not become a reality for many of them, especially those who were ethnic minorities.

In arguing for widows' pensions, the women's and early social work movements unified behind widows' pensions and argued that mothers should not work but rather care for their children at home. Jane Addams is quoted as saying that the working immigrant mother is "bent under the double burden of earning the money which supports her children and giving the tender care which alone keeps them alive" (Fein and Clarke-Stewart 1973:16). This belief that mothers should not work outside the home shaped the creation of Aid to Mothers with Dependent Children, discussed in chapter 1.

During World War II, when large numbers of mothers were needed in the labor force, Congress passed the Community Facilities Act, also known as the Lanham Act. Funding for the Lanham Act nurseries was provided through education rather than social services (Steinfels 1973; Tuttle 1992). Believing that the care of mothers was vital to young children, many social welfare workers remained opposed to any service that seemed to encourage mothers to work outside the home. Prior to passage, there were articles and speeches that warned against women working. Frances Perkins, the only woman in President Franklin D. Roosevelt's Cabinet, is quoted as saying to Children's Bureau staff, "What are you doing to prevent the spread of the day nursery system which I regard as a most unfortunate reaction of the hysterical propaganda about recruiting women workers" (Goodwin 1994:416). By the end of the war, almost $50 million had been spent on early care and education; in July 1945, more than 1.5 million children were being served. Despite 5,914 letters, wires, cards, and petitions in favor of keeping the Lanham Act nurseries open, the effort resulted in a mere four-month extension in funding (Tuttle 1992). There is evidence that many social workers did not support continuation of the nurseries, and at least one governor accused advocates for retaining the nurseries of being communist sympathizers.

After World War II, the social work profession continued to view children whose mothers worked as deprived. Although day nurseries were encouraged to "incorporate much of the educational methods of the nursery school into their programs," they were also urged to provide

casework services for parents (Department of Social Security 1949:1). At the national level, Beer wrote, "the day nursery is a social agency because of its connection with a social problem, the employment of the mother" and noted "the plight of children left without a mother all day" (Beer 1957:10).

Head Start, a comprehensive program specifically targeted at low-income children, began in 1965 as part of the expansion of federal social programs at that time. Head Start was designed as a comprehensive array of early education and support services and provides medical and dental screenings and referrals, nutrition services, and parent involvement activities as well as a child care component. In 1994, Head Start was expanded to include Early Head Start, which is targeted toward young children from birth to 3 years of age and low-income pregnant women. Unlike other early care and education services, Head Start programs are funded directly by the federal government and typically operate on a part-day, part-year basis. Despite budget challenges related to the Great Recession that began in 2007, Head Start funding continues with bipartisan support in Congress, and many states have increased the availability of services by using state funds to create pre-kindergarten programs.

The Changing Economy and Workforce

In the last quarter of the twentieth century, wages for working class men and women in the United States stagnated and fell. This was accompanied by growing disparities in income and wealth between rich and working class Americans. The changes in the economy, combined with increased opportunity and a greater number of single-headed households, contributed to dramatic increases in the labor force participation of mothers. Hernandez (1996) argues, "if children had available only the income from fathers living in the home, then the relative poverty rate would have fallen sharply during the 1940s, much more slowly or not at all during the 1950s and 1960s, and it would have increased substantially during the 1970s and 1980s." From 2007 to 2012, the U.S. economy experienced its most extreme recession since the Great Depression, with families experiencing declines in family income and net worth. In 2010, 26 percent of children under age 5 lived in poverty (Kids Count Data Center 2011).

In 2010, 61 percent of mothers with an infant or toddler (under age 3) were in the labor force. Of mothers of children under 6 years of age, 64 percent were working (U.S. Department of Labor 2011). This compares to 34 percent with infants or toddlers and 39 percent with children under 6 in 1975. Sixty percent of children under age 5 (12.5 million) were in a regular child care arrangement in 2011. Among children under age 5 with an employed mother, only 12 percent did not have a regular child care arrangement; on average, these children spent thirty-six hours a week in care (Laughlin 2013). Among grade-school-aged children (ages 5–14 years) with employed mothers, 64 percent were in regular care including organized after-school programs.

According to an analysis by Child Trends (2012), the types of care used by employed mothers with children under 5 has changed only slightly over the past twenty-five years, with the exception being a steady decrease in the percentage of children in nonrelative home-based care. In 2011, among children under age 5 with employed mothers, 36 percent were cared for by a parent during working hours, 32 percent by grandparents, and 10 percent by a sibling or other relative (Laughlin 2013). Other forms of early care and education included child care centers, 21 percent; nursery schools, 8 percent; Head Start or schools, 6 percent; family child care, 8 percent; and other home-based care, 10 percent. Multiple care arrangements were common with 27 percent of preschoolers under age 5 regularly spending time in more than one arrangement (Laughlin 2013). Mothers who worked full-time and had more education and higher incomes were more likely to have

children enrolled in center-based programs, while Hispanic children were less likely than white or black children to be in such programs (Child Trends 2012).

Parental Preferences in Early Care and Education

Research suggests that parents look for provider warmth and attentiveness and someone they can trust. However, early care and education is one of many complicated decisions that families make in meeting their employment and child development goals. Early care and education decisions occur within the context of family and community characteristics—taking into account the parents' personal beliefs and preferences, family structure and characteristics, work requirements, logistical considerations, and the need for flexibility (Chaudry, Henly, and Meyers 2010; Emlen 2010; Weber 2011). For instance, early care and education choices may be limited by a parent's work hours, transportation, and the affordability of care. A change in employment may require parents to rethink their early care and education plan. According to an analysis of 2005 National Household Education Survey (NHES) data related to patterns of care for children under age 3, "The main factor associated with use of center-based care among low-income families is the receipt of financial assistance to pay for child care" (Child Trends 2009:3).

Results from the National Survey of Early Care and Education should add to what we know about the decisions parents make by providing a national picture on the need for and availability of early childhood care and education services. With findings starting to be available in late 2013, this study sponsored by the Department of Health and Human Services surveyed households with children younger than age 13, home-based and center providers, and individuals working directly with children in home- and center-based settings. This study will provide up-to-date information about the early care and education decisions parents are making, and the early care and education workforce, and help better answer questions about how parents at different income levels pay for care and the characteristics of care available to families.

Early Care and Education Costs

The amount paid for early care and education varies by type of care used, child age, race, size of family, family income, and region of the country. The 2011 average annual cost of full-time child care for an infant in a center ranged from $4,600 in Mississippi to close to $15,000 in Massachusetts (Child Care Aware of America 2012). While the overall cost of child care has increased, the proportion of families with an employed mother who paid for child care decreased from 42 percent to 32 percent from 1997 to 2011, reflecting parents' use of relative and other less costly child care alternatives (Laughlin 2013). However, when families with income below the poverty level paid for child care, they spent 30 percent of their income on care. This compares with 8 percent for nonpoor families.

Box 4.5 provides one parent's perspective:

> I work full-time at a prominent business in my community. When I first moved here, I had to look for child care for my 6-month-old son. I tried every possible program available that provides help to low-income families for child care. I found that a single mother who makes $12.00 an hour is not considered low-income. I did not qualify for welfare. I was told that there are over 350 people in my area on a waiting list for non-welfare-related child care. They told me to apply anyway, but not to count on any help. Child care can average from between $400 to more than a thousand per month, per child. That is almost two weeks worth of pay for me. After paying rent there is no money left over for monthly bills, not to even mention my son's food, diapers, and clothes. At this point, I feel I have only two options: (1) I can quit my job and go on welfare so that I can then qualify for child care subsidies or (2) I can keep my job, along with my pride, impose on my family members to provide day

care at a great expense to them, and struggle severely with monthly finances, all the while continuing to live in poverty.

Early Care and Education Resources

Early care and education is, as has been noted, provided by relatives, in early care and education centers, and in private homes. Centers vary in size depending on available space and staff, community demand (centers tend to be larger in urban and suburban areas), and regulations. Family child care homes typically operate in the home of the provider: the numbers of children depend on the ages of children, size of the home, the experience of the provider, and the availability of an assistant. Although states vary in whether they regulate small family child care homes, most states do regulate homes caring for larger groups of children (from seven to twelve children). All states license centers, although certain categories of centers such as those operated by churches or schools or Head Start programs may be exempt from licensing requirements. Whether or not they are required to be licensed under state law, Head Start programs must meet federal performance standards. Standards for state-funded prekindergarten programs are set by states and vary in stringency on issues such as whether teachers are required to have degrees, maximum class sizes, staff-child ratios, and availability of supportive services.

Although most family child care homes are unincorporated small businesses, centers operate as for-profit and nonprofit organizations, with some under the auspices of schools. While Head Start programs are prohibited from charging parents, parent fees are the primary source of revenue in child care. Historically, child care personnel costs have averaged 50 to 70 percent of center budgets with variations that relate to profit versus nonprofit sponsorship (Willer et al. 1991; Helburn and Culkin 1995). Without resources to augment what parents are able to pay (such as in-kind assistance with facility costs, charitable funding, or government grants), early care and education providers are forced to make difficult trade-offs among parent fees, staff wages, and the quality of care provided to children.

Early care and education workers, particularly those working in child care settings, are among the lowest-paid workers in the United States. According to the Bureau of Labor Statistics, the mean annual wage for child care workers was $10.25 per hour (U.S. Department of Labor, Bureau of Labor Statistics 2012). In response to concerns, the Institute of Medicine (IOM) and the National Research Council (NRC) convened a workshop designed to explore challenges and opportunities that relate to the early care and education workforce. The workshop report says, "The research picture is clear—quality of care and education matters to the lives of young children, and teachers and caregivers are central to providing that quality" (Institute of Medicine and the National Research Council 2012:ix). Workshop participants agreed that despite state and federal efforts, problems around inadequate training and education, low wages, and worker turnover are still as vexing as they were thirty years ago. For a variety of reasons including parents' inability or unwillingness to pay what high-quality care costs, the largely female workforce in child care earns significantly less than women with similar qualifications working in other occupations. Workshop participants concluded that in the absence of a "silver bullet," successful solutions will require research, data, and champions who will tenaciously address the workforce problems identified (Institute of Medicine and the National Research Council 2012).

Quality of Care and Outcomes for Children

Studies of programs such as Abecedarian, the Chicago Child-Parent Centers, and the Perry Preschool Project demonstrate the long-range cost-effectiveness of intensive early intervention with at-risk children. The Perry Preschool Project of Ypsilanti, Michigan,

deserves particular note. Created in 1962 as an attempt to remedy the poor school achievement of disadvantaged children, it used highly trained teachers and very small classes. The number of children served was small—123 children in all. There was also a randomly assigned control group, and the two groups of children and families have been followed for more than forty years. Children enrolled in the program had short-term IQ gains that tended to disappear later. However, academic achievement was maintained: program participants had more successful school careers and were more likely to graduate from high school. Crime and delinquency rates were lower and incomes higher (Schweinhart, Barnes, and Weikart 1993). At the age 40 follow-up in 2005, the program group was significantly less likely to have served time in jail or prison, was more likely to be employed, and had higher median monthly incomes (Schweinhart et al. 2005). Reading the reports, one senses a domino effect at work—a better start led to earlier academic success, which led to greater commitment to school, and subsequently to better outcomes.

Along with findings about the importance of early brain development and the effects of stress on the growing child, early intervention research has heightened concerns about the relationship between early care and education quality and outcomes for children. In contrast with early research dealing with attachment and whether or not children were harmed by child care and separation from their mothers, much of the current research seeks to evaluate program and caregiver quality (including interactions between early care and education and parenting) and the aspects of quality that lead to better outcomes for children. Findings from the National Institute of Child Health and Human Development (NICHD) Early Childhood Research Network (1996) suggest that quality may differ across ages of children, with aspects of the environment being important for infants and caregiver characteristics such as child-centered beliefs about child-rearing becoming more important as children get older. And in a study that involved a meta-analysis of twenty research projects and secondary analysis of data from four large early care and education studies (including child care, Head Start, and state pre-K studies), researchers concluded that quality is related to children's academic, cognitive, language, and social skills after taking background characteristics into account, but that improvements tend to be small (Burchinal et al. 2009). This and other studies have resulted in new research that is looking closely at the measures used to assess quality, the relationship between what is being measured and desired child outcomes, and the possibility that benefits in terms of children's development may not occur until quality is in the good to high-quality range.

The Head Start Impact Study began in 2002 when researchers began tracking nearly five thousand children over time, comparing children in Head Start with those not receiving Head Start services. The results indicate that some subgroups of children show measurable gains, particularly children from high-risk households, children with special needs, and children from non-urban settings (Child Trends 2011). However, findings are mixed, with few measured differences between the treatment and control groups at the end of first grade. This has led to questions about whether children in the treatment and control groups experienced early learning experiences that differed (20 percent of the children in the treatment group never enrolled in Head Start, and up to 60 percent of the children in the control group participated in another early care and education program); whether we should be paying more attention to noncognitive skills such as self-control and other social-emotional gains that contribute to the long-range gains observed in programs like Perry Preschool; strategies for improving Head Start outcomes; and the quality of education children receive once they enter public school.

Federal and State Early Care and Education Policy

While federal support for Head Start has been ongoing since 1965, support for other early care and education programs has been mixed. In 1971, federal legislation that would have instituted funding and standards for child care was vetoed by President Nixon. Despite the veto, progress was made in the 1970s toward increasing resources for early care and education through the provisions of Title XX of the Social Security Act, under which funds were provided to states to initiate "comprehensive social services programs directed toward achieving economic self-support and preventing dependence" (National Association of Social Workers 1987:787). During the early 1980s, this support eroded, as Title XX funding was cut, and business involvement in early care and education was encouraged. By the mid-1980s, the changing economy and family and early welfare reform efforts, along with cuts in federal support to child care, began to reveal the gaps in the nation's early care and education system. A number of state governors formed task forces to develop recommendations for improving child care services and systems. National and state coalitions formed a powerful advocacy voice. The Child Care and Development Block Grant Act was signed into law in 1990 as a discretionary program subject to annual appropriation; it was the culmination of a lengthy debate about the role that federal government should play in child care. Funds were granted to states, territories, and tribes with the requirement that the money be spent primarily on child care subsidies to facilitate low-income families' access to the child care market. States were required to provide subsidized families with choices from among the same types of care as privately paying families. The focus on subsidies for low-income working families and parent choice continues in the Child Care and Development Fund (CCDF), a block grant established under the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (welfare reform). Federal stimulus funds through the American Recovery and Reinvestment Act (ARRA) were helpful to states in maintaining their child care subsidy programs through the Great Recession. However, by 2011, low-income families in thirty-seven states were worse off in terms of child care access and affordability than they were in 2010 (Schulman and Blank 2011). For example, four states lowered their income eligibility limits during this period, family co-payments increased in a quarter of states, and more states had waiting lists for child care subsidies.

Despite the Great Recession, the past decade has been one of tremendous expansion in state-funded pre-kindergarten programs. The percentage of 4-year-olds enrolled in state pre-kindergarten programs doubled from 14 percent in 2002 to 28 percent in 2011 (Barnett et al. 2011). While the percentage of 4-year-olds served increased during this period, many states reduced the amount they spend per child. Adjusted for inflation, between 2010 and 2011, state funding per child declined in twenty-six of the thirty-nine states with pre-kindergarten programs. This raises concerns about whether quality benchmarks such as early learning standards, teacher qualifications and training, and staff-child ratios are being met.

Despite these issues, a comprehensive vision for early care and education appears to be emerging at the national level. This is reflected in federal funding for State Advisory Councils and the Race to the Top–Early Learning Challenge Grants and an administration proposal to expand early care and education services. State Advisory Council grants were authorized through the Head Start Readiness Act of 2007 and funded through ARRA. These grants required councils to take steps toward collaboration across early care and education including assessing the quality and availability of high-quality care and addressing opportunities and barriers to collaboration, unified data collection, and the professional development

of the early care and education workforce (U.S. Department of Health and Human Services 2013). And as of 2013, fourteen states had received funds as part of the Race to the Top–Early Learning Challenge Grant to improve the quality of early learning and help close the achievement gap for children with high needs. States receiving these grants must integrate and align resources and policies across agencies and design and implement a statewide tiered quality rating and improvement system. Significantly, this program defines early education broadly to include home-based as well as center-based programs and encourages states to establish clear standards, supports, and incentives for quality improvement in early care and education programs.

Finally, additional federal-state partnerships are being proposed. Citing the fact that the United States ranks twenty-eighth in the world for the enrollment of 4-year-olds in early learning and twenty-fifth in public investment in preschool, the administration's 2014 budget proposes matching grants to states for development and implementation of high-quality preschool programs for 4-year-olds (U.S. Department of Education 2013). It would also increase funding for early intervention programs, Head Start, Early Head Start, home visiting, and the CCDF. While states would be given discretion in the design of pre-kindergarten programs, programs would be required to have well-trained qualified teachers who are paid wages comparable to K-12 staff, small class sizes and low adult to child ratios, rigorous curriculum, comprehensive health and related services, effective program evaluation, and comprehensive data and assessment (The White House 2013). Over time, states would take responsibility for the education of 4-year-olds, and Head Start funds currently spent on 4-year-olds would be shifted into programs such as Early Head Start for younger children. While the proposal focuses on children in families with income under 200 percent of poverty, states would be encouraged to make pre-kindergarten services available more broadly. The Early Head Start expansion would include a strong child care component so that families would have access to full-day services.

A Critical Look at Early Care and Education and Early Learning

Current state and federal efforts to expand and improve early care and education occur against a backdrop of conflicting attitudes about the role of mothers even though a majority of mothers are now in the labor market within a few months of giving birth. The lack of a coherent system of early care and education has been apparent across history in times of change and national crisis. This was true during World War II when mothers needed to work in the wartime industries. It was also true when increasing numbers of mothers entered the workforce in the late 1970s to help their families respond to the shifting labor market and again when welfare reform required employment for low-income mothers in the 1990s. Currently, global competition and concerns about our education system along with budget deficits and the demands of an aging population again call into question our fragmented approach to early care and education.

Efforts in the 1990s to increase federal involvement demonstrate how embedded early care and education is in history and ideology. While the CCDF is but one of several major efforts to respond to the early care and education needs of working families, it involves the largest appropriation of funds and represents the broadest expression of federal policy. Oriented primarily toward the needs of the poor and at-risk families, the service is intended primarily to enable low-income parents to work rather than to further the development of children. By its connection with welfare reform and TANF, the link between child care and poverty is perpetuated. In a continuation of the debates over the Child Care and Development Block Grant, market interests won out over those who advocated for strategies more analogous

to public education, Head Start, or even the military child care system.

Underlying the CCDF is the assumption that if parents are given necessary resources, including vouchers and information, market forces will produce the supply and quality of care needed by low-income families. This assumption inadequately takes account of the failures inherent in the child care market including (1) the extraordinary challenges faced by low-income parents who struggle to manage work, family responsibilities, and child care and often work in jobs that lack benefits and require non-standard-hour work; (2) inadequate acknowledgment of society's human and collective interest in the long-range development of all children; (3) implicit subsidies made by child care workers in the form of foregone salary amounts; and (4) the failure of the market to produce the high-quality services that have been shown to benefit low-income children.

Possibilities for the Future

With increased evidence about the importance of the early years and the effectiveness of high-quality early care and education services in promoting positive developmental outcomes for children, attention has largely shifted from making sure that low-income parents have the child care they need to work to focusing on the quality of early care and education children receive. Among states, this has generally meant expanding the number of 4-year-olds in pre-kindergarten programs and implementation of strategies to encourage child care quality improvements. Concurrently, many states have reduced their funding for child care subsidies, and there are indications that parents are managing child care costs by turning to relatives and friends.

While in its vision for a more integrated early care and education system, the Obama administration's proposed expansion of early care and education programs is promising, it faces a difficult battle in a divided Congress and potentially contentious debates among stakeholders in early care and education. History tells us that challenging issues and questions will be raised. Questions will come from those concerned about expanding government involvement and expenditures, those with a particular stake in the current system, from parents and advocates with concerns about gaps that are likely to remain, and from state policy makers. From those who oppose expansion of government, there will likely be questions about government intrusion into family matters and the long-term effectiveness of early care and education in producing academic improvements in children. To the extent that early care and education programs are expanded, it should be through block grants to states and mechanisms such as scholarships, vouchers, and tax credits that maximize parental choice of programs (Whitehurst 2013).

Among those with particular interests in the current system, including child care providers, Head Start, and teachers' unions, questions will likely center on how programs are designed. From the perspective of child care providers, will pre-kindergarten programs compete with existing programs for children? Will the financial viability of child care programs suffer, especially as it is more costly to care for younger children? Some states have dealt with competition and expansion issues by allowing child care programs to provide pre-kindergarten services for eligible children thereby creating incentives and additional funding for child care providers offering high-quality services. How well this works may depend on the approach to funding. One study found that in Oklahoma where the pre-kindergarten funds flow to schools, few schools chose to include child care providers in the provision of services. This was in contrast with Georgia, which offers vouchers that follow children to the state-certified provider of the parent's choice. Georgia's pre-kindergarten program resulted in expansion of programs in both the public and private sectors (Bassok, Fitzpatrick, and Loeb 2013).

From the perspective of existing Head Start programs, questions are likely to be raised

about the proposed partnerships with states and the shift of 4-year-olds from Head Start to pre-kindergarten programs (4-year-olds represent approximately 50 percent of the children currently served through Head Start). Issues of organizational stability and funding aside, Head Start has operated for nearly fifty years with direct funding from the federal government to local programs. A proposal to give states control of Head Start funds in the early 2000s resulted in a powerful and successful mobilization against the proposal by Head Start programs and their advocates. Opponents argued that shifting control to states would likely undermine funding and standards for Head Start programs and result in inconsistent implementation of programs across states.

From the perspective of teachers' unions, questions are likely to be raised about any use of vouchers for pre-kindergarten programs, which would be seen as further opening the door to parental choice and vouchers in K-12 education. And, while research has not established a clear relationship between degrees and outcomes for children, the administration proposes to require states to pay pre-kindergarten teachers in line with K-12 staff. Again, this responds to possible union concerns and would increase the feasibility of pre-kindergarten programs being integrated into public schools. This is a significant issue with implications in terms of costs, availability of qualified teachers, and the ability of child care providers to meet the requirements to operate pre-kindergarten programs.

From the family and parent advocacy perspective, there are likely to be questions about access to early care and education for middle-income families, the availability of full-day, full-year services for working families, and parental choice through the CCDF. Will moderate-income families have access to state pre-kindergarten programs or will these efforts make child care even more expensive, resulting in even more families not being able to afford early care and education for their children? And for lower-income families, will efforts to improve the quality of services being provided through the CCDF result in states restricting subsidy use to high-quality child care programs? If so, how will this affect parents who work non-standard hours, live in rural communities, or have a child with special needs? If low-income families can't find care that meets state requirements, will they be forced to use unpaid care or to pay for care out of their own limited budgets? At a deeper level, is the impulse to limit choice under CCDF class-biased, as we don't seem to discuss taking similar steps for middle-income families using the child care tax credit?

Finally, from the state policy and funding perspective, all but ten states currently offer state-funded pre-kindergarten services to some children. Given the budget challenges of the recent past and the reaction of some states to national health care reform, states are likely to be concerned about assuming responsibility for the education of all 4-year-olds. However, unless there are stringent regulations against supplantation, some states may see it as a short-term opportunity to replace state pre-kindergarten funds with federal dollars.

There are no easy answers to these and the many other questions that will be asked in moving toward a more integrated system of early care and education. Thoughtful policy makers, practitioners, and advocates struggle on an ongoing basis to understand the possible effects of policy choices, taking into account what research says and balancing goals and needs that often seem competing. In this regard, more and better research is needed to help tease out the implications of varying policy decisions.

We have the beginnings of an integrated long-range vision for early care and education that includes high-quality pre-kindergarten programs for 4-year-olds and expansion of other early care and education programs. Powerful interests will seek to influence and even derail this vision in line with their own particular interests. As citizens and advocates, it will be important to focus on the goal—ensuring

that all young children are prepared to succeed in school and life. That said, we need to reflect critically on what it is we are working toward. Is our vision limited by traditional views about the role of mothers and belief in individual responsibility as opposed to recognizing the roles that class, race, and sex play in creating an uneven playing field? To what extent does our own peculiar investment in the current system shape our views about the types of changes that are possible and desirable?

It is unclear the extent to which the current proposal for early care and education will succeed, and if successful, whether it will lead to stable infrastructure and funding that is less vulnerable to political winds than our current mix of vouchers, tax policies, and grants. If prekindergarten programs for 4-year-olds become a state responsibility, will these programs become part of the education establishment, and what will that mean in terms of parental choice and costs, hours of service, standards, and funding over time? However, it is possible that this proposal will be an important step toward the universal availability of quality, affordable early care and education services for all families and their children.

Conclusion

All of the community support services reviewed in this chapter are critical to child welfare services. Some are needed by most families and are, or should be, part of the overall social services system. Many of the services for families needing extra support were once incorporated into the structure of the public child welfare system. Others have developed as innovative programs to meet the needs of families as new needs appeared or existing ones were recognized. Many are now linked to public child welfare agencies through contractual arrangements. These are the services that provide the specialized interventions and the ongoing support that enhance the functioning of families in our complex society.

In this chapter and chapter 1, the discussions of the basic family support have been somewhat more extended than the discussions of more specialized services. This emphasis reflects the bias of the writers. In child welfare, we often discuss prevention of abuse and neglect and other family difficulties. It is only in recent years that we have developed sophisticated research studies, have begun to identify the services that do prevent later problems, and are beginning to invest in them to a greater extent. The family support services that are the subject of this chapter, the income maintenance programs of chapter 1, and the experiences of early childhood are critical services in preventing later difficult and expensive problems.

Early care and education is a vastly important issue as family structures change and parents move into the workforce. It complements the services designed to support parenting skills and family functioning. As we learn more about early child development, it becomes clear that investment in these early years is perhaps our most effective means of preventing a host of poor outcomes.

NOTES

1. Increasingly, child welfare agencies are going to seek to use parent-training programs whose efficacy has been demonstrated. The California Evidence Based Clearinghouse for Child Welfare (www.cebc4cw.org) is a resource for identifying these programs. It shows, in 2014, the Incredible Years training program described here and three others as having a rating of 1, "well supported by research evidence."
2. This dilemma is described in Janet Fitch's moving and well-written book *White Oleander* (Boston: Little, Brown, 1999). The novel follows the experiences of a mentally ill mother, incarcerated because of a murder, and her young daughter in foster care.

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5

Crisis Intervention

Preservation of Families for Children

I felt my standpoint shaken
In the universal crisis.
But with one step backward taken
I saved myself from going.
A world torn loose went by me.
Then the rain stopped, and the blowing,
And the sun came out to dry me.
—Robert Frost, "One Step Backward Taken"

In this chapter, we are nearing the top of the pyramid described in chapter 4 and considering intensive services needed by a relatively small proportion of families. This chapter is about families in which the children are at risk. Either they have been harmed through their caretakers' abuse or neglect, or they are at risk of harm. These are children who need immediate action for their protection. Their parents may need intensive services so that the children can remain at home or the children may have to be removed from the home. The hope is that the children can remain within the family.

Intervening to Protect Children

When a report comes to child protective services and an assessment of the situation reveals that there has indeed been abuse or neglect or that risk to the children is high, the worker must make one of the most difficult decisions in social work practice. Removal of a child or children from the home and placement in foster care is a common response and ensures the immediate safety of the children. However, as we have already noted, the trauma involved in separation presents its own risks to children. If the family can be supported so that the child can remain within the family, the child is much better off.

The last two decades of the twentieth century saw two major initiatives that it was hoped would create good outcomes for children, protecting them and keeping them within their families. Family preservation services that attempt to improve conditions so that children can remain with their parents were developed and became popular. Kinship foster care also grew to provide an alternative within the extended family when it was not possible for a child to remain with parents. It is this process of preserving families for children that is the topic of this chapter.

The Concept of Family Preservation

Family preservation is the goal of maintaining a child within the circle of the family—his parents, grandparents, aunts and uncles, the family that we call extended family—if at all possible. It also has come to signify a specific model of services to strengthen the family and avoid placement of children. As a concept, it has guided child welfare in an on-again, off-again way over time, retreating as the child rescue movement took shape, advancing with the idea of mothers' pensions and income maintenance, retreating with the "discovery" of child maltreatment in the 1960s and 1970s, advancing with the recognition that children were spending years "drifting" in foster care and the remedial legislation of the Adoption Assistance and Child Welfare Act of 1980 (which demanded that each child in foster care have a case plan and that there be periodic reviews of that plan), and, most

recently, retreating with the Adoption and Safe Families Act and a new emphasis on adoption. The goal of preserving families has always been in the background of child welfare services; it is the impetus behind the family support services explored in chapter 4, the array of services targeted to the prevention of abuse and neglect, and, of course, the development of a specific intervention model called *family preservation:*

> What is revolutionary about the family-based services movement is its rejection of a world view which blames families for their failures in child rearing and sees foster care or institutional placement as the best way to save children. In place of this old world view, the family preservation movement holds forth a new vision: one which sees that families are worth saving, as well as children. . . . The new model of child welfare differs from the old paradigm in valuing families' strengths and respecting their needs and views, even in the face of serious child maltreatment. Family-based workers recognize that an essential part of their job is to instill hope and engage families in a process of change which is both goal-oriented and time limited. And while preventing placement is most frequently seen as the primary goal of family-based services, families, workers, and agencies all know that this can only be achieved through improvement in family functioning, social, material, or psychological, which allows children to remain safely in their own homes. (Nelson and Landsman 1992:3)

The concept provoked fierce controversy when first implemented. Critics asked why one would attempt to preserve "bad" families for children when adoption into "good" families was possible. Bartholet noted that family preservation had become "a mindset that dominates the thinking of people who make and implement child welfare policy from top to bottom, in the public agencies and the private foundations, in the courts and the legislatures" (Bartholet 1999:114). Media highlighted stories of tragic mistakes in which children were left in homes or returned home and harmed.[1] The controversy quickly triggered research (discussed later in the chapter) to monitor the consequences of family preservation.

An interesting aspect of family preservation in the past fifteen years has been the expansion of the concept of family. We noted in chapter 1 that a smaller proportion of families now consist of the traditional mother-father-child constellation. Blended families, single-parent families, families with same-sex parents, intergenerational families—all have become more prevalent. Family has come to mean the large extended family of grandparents and aunts and uncles and cousins, as well as all of the traditional and nontraditional forms a family can take today. These are the families that the child welfare system attempts to preserve for children.

Family Preservation Services

Family preservation also has a more specific meaning and describes a short-term, intensive intervention designed to prevent the placement of children into out-of-home care. This specific set of services is based on shared assumptions that families have strengths that can be mobilized, and services are delivered with the intent of enabling the family to provide an adequate home for its children. A broad range of services are provided, focused on assessment of family need. Concrete assistance can be as important as guidance in parenting. The family preservation services that developed in the 1970s and 1980s laid the groundwork for the philosophical shift that focused child welfare work more firmly on keeping children with their own families. The difficulties that children experienced in foster care were well understood. This was a model that it was hoped would be more successful.

The Family Preservation Models

Families and Young Children The first of the intensive family preservation models was Homebuilders, developed in the state of Washington in the 1970s. Homebuilders is a

short-term, intensive intervention program. It is based in crisis theory, which postulates that because a crisis state cannot be maintained, its presence opens an opportunity for change. Families are referred to Homebuilders from protective services when there is a high probability that children will need placement in foster care. Each Homebuilders worker carries only two cases at a time; the workers are available to the families as needed, at any time. They work mainly in the home but also anywhere else they are needed. Their work ranges from counseling interventions to help in cleaning an apartment. Service is intensive and brief, lasting between four and eight weeks, and is based on social learning theory. The provision of needed concrete and supportive services is important. The goal is the limited one of stabilizing the family so that placement of children outside the home is not necessary (Kinney et al. 1990).

Evaluation was built into Homebuilders from the start. Early outcomes showed that the families served experienced very low rates of placement. These findings and the attractiveness of the philosophical base generated great enthusiasm for the model. More extensive evaluative work modified this enthusiasm, as it was discovered that low rates of placement were characteristic of both the parents receiving Homebuilders intervention and the control groups (Schuerman, Rzepnicki, and Littell 1994; McCroskey and Meezan 1997).[2]

A short-term, intensive services model, based on family systems, has also experienced success. The home-based model has many of the characteristics of Homebuilders, but it arises from family systems theory. The family as a whole is the target of intervention.[3] Families receiving services participate in the assessment of their situation and in setting treatment goals. Interventions take place over more extended periods, usually around ninety days, and workers carry ten to twelve cases at a time. Family therapists provide a wide range of services in addition to coordinating services provided by other agencies.

Families with Adolescents Two models have proved successful in working with adolescents and their families when there were serious problems. One, the family treatment model, is based on family systems theory. This model is a much more traditional therapeutic model. Sessions can take place in the therapist's office as well as in the home, and interventions often consist only of family therapy. Services are less intensive than those provided in the brief service models and can extend over an indefinite length of time. Workers carry more cases.

A second model, multi-systemic therapy, developed in the 1990s, focuses on intensive work with adolescents and the family and community systems with which they are involved. Like Homebuilders, it is focused on the present and is action oriented. Its goal is to empower families and youth by teaching the skills needed to cope with complex environments. As this mode of intervention developed, there has been considerable attention to ensuring that practitioners were delivering the services in exactly the way that the model intended (Berry 2005).

Multi-systemic therapy has shown success in working with antisocial adolescents and their families, keeping these youth with their families and in the community. There are reductions in family conflict, increases in family supportiveness and communication, and lowered arrest rates for teens after the intervention. Unlike the Homebuilders model, multi-systemic therapy has shown its effectiveness in experimental designs and in a meta-analysis (Kazdin and Weisz 1998, as reported in Reamer and Siegel 2008).

Common Characteristics These four models share characteristics that are the hallmarks of family preservation services. Berry (2005:322) enumerates them as follows:

- treatment is focused on the present, is action oriented, and uses cognitive-behavioral approaches to skill building;

- treatment is embedded in the community and includes all family members as active participants and planners in the intervention;
- treatment is intensive;
- caseworkers have low caseloads so that they can spend extensive time with the family;
- treatment is planned to be relatively short term.

Another common characteristic of these models is that they seek to empower families to participate in planning, in services, and in community life. One goal is to develop or repair a network of supportive services that will be there when the short-term treatment ends.

Community-Centered Practice

Family preservation models, as well as the family support models discussed in chapter 4, rely on the development of community supports for families to achieve long-term success. Community-centered practice is based on the idea that successful family life can take place only in concerned and supportive communities that have the resources to offer opportunity and hope to residents. With its roots in the settlement house movement and the beginnings of social work, community-centered practice is a relatively new idea in the family preservation literature:

> Community social work views professional services as marginal compared to the amount of help and care that is provided in informal social networks and avoids usurping natural helpers and creating disempowering reliance on formal services. Rather than "objects of concern," clients are seen as equal citizens with the same capacities and rights as professionals. In this new light, the professional's task is to promote partnership and collaboration by identifying strengths and mobilizing resources in the community, reframing situations, and modifying destructive patterns. (Adams and Krauth 1995:17)

Many of the ideals of community social work are applied to child welfare in the community partner concept, being promoted since the late 1990s by the Edna McConnell Clark Foundation. The reforms envisioned in this approach would narrow the scope of child protective services so that they dealt only with high-risk families while building a network of community agencies to work with families who need support and help but do not require authoritative intervention.

The Patch Project in Iowa is an example of a community-centered practice model. A team of workers delivers child protective services and other family support services to a specific neighborhood, or "patch." The Patch teams "offer accessible, flexible, and holistic services based on their knowledge of the local cultural and physical environment and on the formal and informal partnerships they develop in their neighborhood, or patch" (Adams and Krauth 1995:87).

A major community building project in Los Angles County, California, illustrates and has demonstrated the potential of a broad community approach. The project worked to strengthen a network of community agencies serving children and families, with goals of prevention of abuse or neglect, as well as strengthening families in which it had occurred. Three groups of families were evaluated: those living in high-risk communities but not involved in child welfare services, those being investigated for possible child maltreatment, and those with open cases after a finding of child maltreatment. In all three groups, parents reported gains in family support, connections to the community, and less parenting stress, all factors linked to prevention of child maltreatment. Engagement of families in supportive services was thought to relieve some of the pressure on child protective services, though it did not result in a significant change in substantiated cases of child maltreatment (McCroskey et al. 2013).

Similar philosophies and techniques are reported in several programs throughout the

country, each program bounded by a geographic "patch" and working to build comprehensive services to those within the boundary. Some programs attempt to modify parenting behavior and strengthen families through use of existing programs, enhancing the capacity of child care centers to connect families with community supports, for example. Others work to create collaboration among existing agencies while encouraging the addition of new services deemed effective in strengthening families.[4] Workers in these projects report spending more time with clients; drawing on both formal and informal neighborhood resources; and defining family problems more holistically, giving more attention to the impact of poverty, housing, mental illness, and substance abuse on the safety and well-being of children (Waldfogel 1998). These approaches work to make it socially acceptable to ask for help with parenting and to make the help readily available. Generally, these programs do not have the intensity in their work with families that is the hallmark of crisis intervention family preservation.

These approaches report mixed results in preventing child maltreatment, with some changes in parenting behavior, little reduction in reports of child maltreatment, and little evidence of increased neighborhood cohesiveness. Daro and Dodge (2008) in their review of community-based programs point out that the impact on the community may take a long time, as there is here an attempt to change attitudes, and then see that change grow into community change. They question whether the extensive investment in community building will impact child abuse, noting that the mixed results of existing projects "raise the question about the value of investing in changing community context over offering direct assistance to parents" (p. 87). These are interesting questions about a dynamic new way of conceptualizing child welfare services. Both the community-based approach and the concerns it raises deserve serious consideration.

The reader will recognize in the description of the community-based approach the philosophy of differential response to child abuse and neglect reports, discussed in chapter 3. The community building that takes place helps to create the conditions that make differential responses possible.

The promise of this approach lies in its emphasis on the community conditions that make it difficult to raise children and the possibility of changing these to supportive conditions. Theoretically, it offers hope for prevention of abuse and neglect. With its basis on listening to community residents as they define their needs and its reliance on the voluntary use of services by stressed families, the model offers promise for changes in communities and families. It rests on the premise that parents, even those who are abusive or neglectful, want to do well by their children and will engage in services to improve their parenting.

Federal Policies and Funding

Though there is considerable enthusiasm for these programs that keep families together, during the 1990s neither legal mandates nor funding followed this enthusiasm. The Adoption Assistance and Child Welfare Act, enacted in 1980, mandated that child welfare services assist in maintaining children with their families and enhance services to prevent separations—in short, make reasonable efforts to prevent out-of-home placement. However, these prevention services never received adequate funding. The Adoption and Safe Families Act (ASFA) put its emphasis on adoption.

Recent research demonstrating poor outcomes for out-of-home care (Pecora et al. 2010; Courtney et al. 2011) and the changes demanded by the Child and Family Services Review (CFSR) have shifted the direction of child welfare services, producing an emphasis on preserving family connections and reunification after shorter times in foster care. Federal funding streams, however, for the most part remain devoted to building programs to

respond to reports of abuse and neglect, to meeting the costs of out-of-home care, and most recently to encouraging adoptions.

Many states have applied for waivers of the requirement that Title IV-E funds be spent solely on foster care. The waivers enable them to experiment with using funds to keep families intact; evaluation of the results of these waivers is expected. In 2012, waivers were given to nine states for projects with a focus on addressing trauma and improving well-being of children and families. The waivers were for a wide range of projects focused on using interventions of proved effectiveness; working with community partners on housing, substance abuse, education, and other concerns of families; and using new tools to keep children within the extended family (U.S. Department of Health and Human Services 2012b). This is a major investment in the concept of family preservation.

Assessing the Effectiveness of Family Preservation Services

Family preservation, as a specific crisis-intervention service to families, was probably oversold at the outset of the movement, when it was promoted as a cost-effective way of preventing expensive foster care placement. As time has gone on, controlled studies have raised questions about whether family preservation models actually lower the rates of foster care placement. Questions have also continued to be raised about whether there has been too much emphasis on preserving families, at the cost of leaving children with—or returning children—to parents when their safety is at risk. The tension is an old one.

A body of empirical data is emerging concerning the effectiveness of family preservation services. Intensive family preservation services were originally marketed as cost-effective because they would keep children out of foster care, so the outcome measure usually applied is the success of the program in preventing foster care placement. There are, however, difficulties with this approach. Placement is not frequent, even among high-risk families involved in the protective service system. Although prevention of placement may be the policy goal of legislatures, it is not the ultimate goal of family preservation services. Rather, their goal is to stabilize families so that they will be safe and nurturing places for children.

The first reports were very positive. The intensive crisis intervention programs reported that more than 90 percent of the families they served remained intact; other models that entailed longer contact with families reported somewhat lower percentages. However, the first studies using a control group could not demonstrate that family preservation services lowered placement rates: the placement rates were low in control as well as experimental groups.

It is very difficult to evaluate the impact of a service designed to prevent an outcome. When, in a series of studies, Homebuilder services were tested with a control group, and the results were disappointing; foster care placement is a relatively low-incidence event, even among families in crisis, and differences between families that received family preservation services and those that did not were small (Fraser, Pecora, and Haapala 1991; Schuerman, Rzepnicki, and Littell 1994).[5] In fact, the largest study of family preservation with a randomly assigned control group, carried out in Illinois, found that placement rates were slightly higher among those families receiving intensive family preservation services (Schuerman, Rzepnicki, and Littell 1994).[6] Only one study, which used archival case records, found that family preservation services prevented foster care—rates in the family preservation group and those in the group that received regular child welfare services were similar, but the group that received family preservation services was at much higher risk (Kirk and Griffith 2004). If placement rates were not lowered, the cost-effectiveness of the programs could not be demonstrated, at least not in terms of the immediate outlay of funds.

Placement prevention may not be an appropriate outcome measure: the goal of family preservation services is to strengthen families

for children. Measuring improvement in family functioning becomes critical. McCroskey and Meezan (1997) carried out a large study with an experimental design in southern California. No one model was tested, but all interventions studied conformed to the basic principles of family preservation services. Families receiving family preservation services showed small but significant improvement on measures of family functioning, while the home environment improved for very young children, and school behavior improved for older children. In general, programs were more successful when physical abuse, rather than neglect, was present and were less successful when there was substance abuse, domestic violence between adults, or a history of parental incarceration. Rates of placement were the same for control and treatment groups. This study also looked at re-abuse rates and found them to be low in both groups.

Dore (1993) noted that family preservation services are less effective for families coping with extreme poverty, single-parent status, low educational attainment, and mental health problems. McCroskey and Meezan (1997) also reported that the concrete needs of families had to be addressed before there was improvement in the interpersonal areas of family functioning. These are important findings and suggest that the inclusion of meeting concrete needs in the Homebuilders model is an important component.

McCroskey and Meezan (1997) also made note of a small group of families that was not able to complete services. These were families in which the caregiver was aggressive or violent and had severe emotional problems. They suggest that a different type of service, one that first addresses violence reduction, is needed by such families. They also note that these may be the very families that, because of the potential for violence against children, call the wisdom of family preservation into question.

Family preservation programs seek to empower families by creating opportunities for them to participate in assessing their difficulties and planning services. In this way they resemble the differential assessments that are being introduced by some child protective service agencies. All of the studies cited here reveal that clients are enthusiastic about the services they receive. If empowerment is a goal (that is, if we truly believe that families are capable of judging what is in their own best interest), then their endorsement itself may be an important indicator of the effectiveness of family preservation services.

In their enthusiasm for a new model of working with troubled families, child welfare professionals and the public may have expected too much of intensive family preservation services. Most of the models are time limited, whereas some family difficulties, such as substance abuse, require long-term support and protective monitoring and will probably continue to demand episodic intensive services. Family preservation services are but one part of the array of services that must be available to protective service workers. No service model will work for all families. One of the basic tenets of social work practice is the necessity of individualizing the needs of each client and designing an intervention package to meet those needs. All of the models of intensive family services described in this section are flexible. Nevertheless, it would be unrealistic to expect any service program to be equally effective for all families as each copes with a highly individual complex of difficulties and needs.

Do Attempts to Preserve Families Put Children at Risk?

When the media report on children who are injured or killed after being left in or returned to their homes, the public raises questions about the wisdom of family preservation services. The difficulty is in deciding when to try intensive family preservation services, when to remove a child from the family, and when it is safe to return a child home, in cases where—as in the majority of such situations—the child is

currently safe from serious injury but the risk of future harm is unclear.

Elizabeth Bartholet is one of the sharpest critics of family preservation services. Her position is well stated in a speech about children's rights:

> My position has been that we need to challenge the balance that our society has traditionally drawn between parental autonomy and the state's role as *parens patriae* so that the state plays a more significant role both in supporting families and in intervening in those families that fall into dysfunction to the degree that the children become victims of child abuse and neglect. . . . The state needs to play this more active role at two distinct stages:
>
> 1. Early intensive intervention: We need to do more up front to support all families so that they have a better chance to succeed. Here the most promising intervention I have identified is Intensive Home Visitation.
> 2. Late-stage interventions: We need to move more aggressively to protect children when families demonstrate that they are failing and children are subject to severe forms of abuse and neglect. We need to place a higher value on children's rights to grow up in a nurturing home, and move them on to foster and adoptive homes early enough to give them a fair chance at life. (Bartholet 2004:217)

The idea of keeping families together is appealing, both to a public that values family life and to child welfare personnel who have witnessed how poor a parent the state can be. There is serious disagreement, however, about how the concept should be implemented. The controversy focuses on family situations in which the risk is hard to evaluate and the questions concern the potential of parents to acquire the attitudes and skills necessary for success. How much help should parents be given, and for how long? Which do children need more urgently, homes with care that meets community standards or homes with their biological families? The problems lie in the implementation of the concept.

One can start with the proposition that children need to be rescued from bad families or one can start with the idea that the "best way to protect children is to preserve as much of their families as possible" (Maluccio et al. 1994:295). The latter is the philosophy behind family preservation services.

Kinship Foster Care

The placement of children who cannot remain in their own homes into the care of relatives has been around for a long time. Traditionally, when there was trouble in a family, grandparents or an aunt and uncle took in children and kept them until their own parents were again able to care for them. The child welfare system has simply borrowed this old practice and has increasingly sought relatives when children needed to come into foster care.

Kinship Care Today

Kinship foster care has grown tremendously in the past quarter century; in 2011, the Adoption and Foster Care Analysis and Reporting System (AFCARS) reported that 27 percent of the children in foster care were in kinship foster care (U.S. Department of Health and Human Services 2012a). Kinship foster care fits into the family preservation movement: a major impetus for its growth has been the expanded concept of family and the increasing investment in keeping children within this expanded family.

Kinship care has been defined by the Child Welfare League of America as "the full-time nurturing and protection of children who must be separated from their parents by relatives, members of their tribes or clans, godparents, stepparents, or other adults who have a kinship bond with the child" (Child Welfare League of America 1994:2). This is a broad definition, recognizing both blood ties and relationships more akin to the "psychological" family of the child. By 2009, half of the states were using this broad definition; in most of the remaining states, policies promote placement of children with biological family members if possible

(Geen 2004). This preference reflects a quarter century of positive experience with kinship foster care.[7]

Policy Issues

As kinship care evolved, it occupied a middle ground between the informal kinship care of the past and the licensed and supervised nonrelative home that child welfare agencies were accustomed to using. Policy appropriate to this new form of care has slowly evolved. The result is a complex system, with wide variation among the states.

Types of Kinship Care Children being cared for in the homes of relatives may have been placed in these homes through a child welfare agency or the arrangement may be a private one between the parents and foster parents. Private arrangements for care are far more common. In 2004, the U.S. Census counted approximately 2.4 million children in the United States living apart from their parents and with relatives; about half of these were living with a grandparent (Kreider 2007). Some portion of these children have had contact with the child welfare system and have been "diverted" from that system into the homes of family members without the child welfare system taking custody or providing services. For others of these children, the child welfare system is providing services to the family and has arranged or approved the placement without taking custody.[8] For another portion, the child welfare system has taken custody of the children and has placed them with relatives in formal kinship care. Over time, informal kinship homes tend to be absorbed into the formal system (Testa, Bruhn, and Helton 2010).

Payment for Care Financial support for private kinship care placements is provided, if the family applies for it and qualifies, through the state's income maintenance programs, food stamps, and Medicaid. The Temporary Assistance for Needy Families (TANF) grants are for the child only and amount to much less than foster care payments. This augments the income of the foster family, and there is no connection to the services or supervision of the child welfare system. Under TANF, it is up to states to decide whether their block grants will be used for the support of children in relative foster care and whether any time limits apply to these children.

The appropriateness of paying relatives to care for children has been debated; some observers contend that relatives should care for children out of family obligation alone. In Illinois, a class action suit was brought by relative foster parents, who sought the much higher maintenance payments available to nonrelative foster families. In 1979, the Supreme Court ruled in *Miller v. Youakim* that Congress intended relatives to receive the same maintenance as nonrelatives and that states are obligated to make these payments and, for Title IV-E eligible children, are entitled to federal reimbursement. These higher payments come, however, with more regulation of the home and lessened decision-making capacity.

In formal kinship care, the relative's home is held to foster care licensing standards; is under the supervision of the child welfare agency, which retains the ultimate decision-making authority for the child; and receives the same level of payments for the child's maintenance as an unrelated foster family would. If an assessment of the child's and the family's needs and of risk suggests that services will be needed, a formal kinship care placement involving the child welfare system is the most appropriate (Scannapieco 1999).

Licensing A license for a foster parent is like any other license: a statement that the home or person or institution has met certain standards and is competent to do what it is licensed to do—in this instance, care for children. For traditional foster homes, a license usually follows a home visit, background checks, and training in caring for children as a foster parent. When relatives first began to be used as foster parents, a question was raised about the appropriate assessment

and licensing requirements for relative homes. These were homes that knew the children they would care for and often were already involved in their care. Procedures that would ensure the safety of children in the home were thought necessary, but training around child care seemed inappropriate, and many states used expedited procedures for relative placements.

The Adoption and Safe Families Act made federal reimbursement for foster care payments contingent on the foster home meeting the same licensing standards as nonrelative foster homes. ASFA requires that all foster parents undergo a criminal background check and a check against the child abuse registry. States have attempted to use differing assessment procedures for kinship foster homes, giving states flexibility to use kinship homes even when relatives cannot meet all licensing requirements, but the approach has been rejected by the federal government, which insists on the safety provided by licensing standards. However, requirements not considered essential for safety are in practice sometimes waived for relatives. Ability to care for the child, ability to meet any special needs, and willingness to work with the child welfare agency are necessary. Only fifteen states require kin to meet exactly the same licensing requirements as non-kin (Geen 2004).

It has long been recognized that placements in kinship foster care are very stable. NSCAW data show that as the placement continues, informal arrangements tend to become formalized with homes being licensed and foster care payments being made (Testa, Bruhn, and Helton 2010). ASFA exempts relative placements from the rule that a petition be filed to terminate parental rights when the child has been in foster care for fifteen of the most recent twenty-two months. Thus, placements in kinship foster care can eventually turn into situations in which the foster family takes guardianship or adopts the child. This suggests that considerable care needs to be taken in the initial licensing of the relative home and that procedures that create fewer requirements may not always be wise.

The example of box 5.1 illustrates the complexity, the rewards, and the strains of prolonged kinship foster care.

BOX 5.1

Nora is a child in kinship foster care. She is now 11. At age 7, she was removed from her mother, who was living in an abusive relationship and having problems with drugs. She has lived with her aunt in kinship foster care for four years and is soon to return to her mother. Her aunt is her foster parent, speaking throughout this chapter:

"Well, my sister had a bad habit of leaving her . . . leave her for a weekend, come back in a week. Leave her for a week, come back in a month."

[Family friends took Nora, age 7, to the beach for a week.] "It had been five weeks and no contact with her mother and they couldn't find her. She [called me] and said, 'I have had Nora for five weeks and I don't know what to do.' I said, 'I'll be there in twenty minutes.' I picked up Nora with the clothes on her back, got in the phone book, hired an attorney, and took her to court. . . . I literally saw this kid who was angry, nightmares, didn't want to sleep in a room by herself, had no clothes on her back, poor hygiene, no manners. I just thought, 'Oh, my God, oh, my God. Literally, I don't know if I can do this.' Then I just thought, 'Well, somebody has got to do it.' And that's how it sort of happened. Then we just became a team."

The Foster Parents

Kinship caregivers face many challenges. They agree to take in children from their own extended family because they are attached to them and want to be sure they have good care. Sometimes they take them in from a sense of family obligation. The situations of many are such that, without the impetus of wanting to care for a specific child, they would not have added a child to the family.

Demographics Descriptions of kinship foster parents almost universally find that poverty is an issue: one study found that 39 percent of

children in kinship foster care live in households with incomes below the federal poverty line (Ehrle and Geen 2002).[9] NSCAW data confirm this, indicating that 41 percent of relative foster parents have incomes under $25,000 (U.S. Department of Health and Human Services 2001). Almost half of the children being cared for by relatives are being cared for by grandparents, and most children living with grandparents have brothers and/or sisters living in the same household (Hegar and Scannapieco 2005). Kinship foster parents are disproportionately African American. They tend to be older than regular foster parents, are more likely to be single, have less education, and have poorer health than traditional foster parents (Berrick, Barth, and Needell 1994; U.S. Department of Health and Human Services 2000; Ehrle and Geen 2002; Scannapieco and Hegar 2002; Testa, Bruhn, and Helton 2010). They have relatively little experience as foster parents (U.S. Department of Health and Human Services 2000).

Needs These characteristics suggest that these are families that will need considerable support if they are to offer stability and developmental opportunity to the children in their care. Scannapieco and Hegar (2002) suggest that the domains of financial support, services needed by the child, social support for the foster parents, and educational planning for both child and foster parents be considered as service plans are developed. Additionally, foster parents need to be able to discuss their questions and concerns with the child welfare worker, and the worker needs to have a good knowledge of the child and the family situation.

Because many relative foster families live close to the poverty level, financial support is critical. Adequate reimbursement for foster care is very important to these foster parents; state policies and caseworkers should encourage application for full foster care payment. Assistance in bringing homes into conformity with state standards for the safety and health of children may be needed by some of these families if they are to be licensed and receive full foster care payments (and if the children are to be in healthy and safe homes). Adequate clothing allowances are important. Relative foster parents may not have the funds for recreational and social opportunities for the children in their care, and the child welfare agency needs to be aware of these needs and meet them as generously as possible. Help with transportation to appointments can be greatly appreciated.

The children placed in kinship foster care come into their foster homes with the multiple needs of any child who has been abused and/or neglected. Relative foster parents may need encouragement to be advocates for their foster children with the school system, particularly if the children need special services or individual educational plans. They need guidance around the legal system and preparation about what to expect when they or the children are to be present in court. As the children in their care exhibit difficulties, they may need help in identifying appropriate mental health resources; mental health services may involve the caregivers and other family members, as well as the children. The caseworker needs to ensure that children receive any needed medical and dental care. Children in relative care are covered under Medicaid, but the foster parent may need help in finding providers that accept Medicaid.

The worker will need to encourage kinship families to become connected with community support systems, such as churches, community centers, and so forth if they are not already involved. Additionally, the worker should facilitate the building, or rebuilding, of family support networks. Respite care, if needed, can often be found within these networks of family and friends.

Anyone starting on a new venture needs education about it; so relative foster parents need information and supportive help as they take on this new role. Some systems provide formal training of the kinship foster parents, some do not. In either case, circumstances often bring a child into a relative's home when there has

been little opportunity for preparation. As a placement progresses, the caseworker can often identify areas in which the family could use some extra education. Working with the family to identify those needs and then helping the foster parents access appropriate resources can be important contributions.

Finally, relative foster parents need a supportive and open relationship with the caseworker supervising the foster home placement. The worker needs to be available when needed. A prompt response to telephone calls and requests is mandatory. Crises build in foster homes, particularly as families build new networks of relationships. An active response to a crisis can prevent a placement from disrupting.

In box 5.2, the relative caring for her niece that we met earlier in the chapter describes her needs.

BOX 5.2

"I think that the behavioral displays and me not having even been a parent before, and having been a single person with a complete life of my own prior to having her, I think that I wanted assistance also in how to deal with getting her back on track. . . . I was looking for practical ways to resolve the outbursts and the mood swings and the anger quickly, without getting frustrated myself. And I was looking for tools. So I would say between the school counselor, her teacher, and our counselor [provided through the child welfare agency] . . . and then a lot of the people I work with are grandparents their own selves and they have a lot of practical parenting skills. I read books . . . "

Children in relative foster care present the full range of challenges of children in any situation. When placements continue for long periods, relatives may experience exhaustion and a sense of helplessness. Their sense of family obligation and attachment to the children may seem to preclude any future change in circumstances—the length and stability of these placements may then not be of advantage to either children or foster parents. An active worker who can organize mental health or other services and work with the family to create change will be needed. Respite care can be vital, as can support groups.

The Children

The children coming into kinship foster care have experienced abuse and/or neglect severe enough that they were removed from their homes. Basic needs for well-child care and dental care are often unmet. Many come from homes in which substance abuse has been a problem. They are coping with the trauma of being separated from their parents, though the trauma is somewhat mitigated if they go to the home of a relative they know. Their parents usually have more access to them in relatives' homes, so that visits can be frequent and informal, which also assists a child in managing a separation. However, children in kinship foster care suffer from the mental health and behavioral problems that are the aftermath of abuse and neglect.[10] Relatives need expert help in managing their behaviors and providing the most therapeutic environment possible. The services described in the preceding section are important.

Data from NSCAW indicate that kinship care seems to support the well-being of children quite well. The trauma of separation from parents is somewhat mitigated by placement with known family members. Children in kinship foster care appear to be more content than in other types of placements; they like their foster parents, and 35 percent report wanting the placement as a permanent home. They tend to discuss school and dating with their foster parents. They also have more frequent visits from family (Chapman, Wall, and Barth 2004).

Kinship foster care is different from regular foster care. In some ways it seems more natural, an extension of the long tradition of extended family care of children, and thus to be an easier service to administer than regular foster care. Agencies may expect it to require fewer services and less attention. In some ways, though,

it is much more complex. Kinship foster care incorporates the tensions of a family that has had difficulty with its children, with caretaker and parent roles shifting. Additionally, relatives are often motivated by affection and family obligation and may take on the care of children without sufficient resources of either finances or energy to handle the task easily.

The foster parent we are following describes this complex relationship in box 5.3.

BOX 5.3

"I think that there is a special history that follows a biological placement, and I think that the caseworkers would benefit from having some specialty training there, as well. In other words, there are just different attachments and there are different histories of how a grandparent or a sister or a mother will deal with the history of the biological parent, and making it more like a divorce.

"But I really felt all along that I wanted to stay separate from my sister and Nora's relationship, whatever that might be. . . . But I could see [the child welfare agency] kind of wanting me to be in it when they wanted me to, and wanted me to stay out . . . when they wanted me to. . . . It was very strange. So I chose to stay out and try to neutralize myself. Other than my love for Nora, but to try to stay at a distance. Like a foster parent."

Supporting Kinship Foster Care Placements

As long as a child is in a licensed foster home, the child welfare agency has the responsibility to see that the child is safe, that the home provides opportunity for optimal development, and that the placement is stable and the goal remains a permanent home for the child.

Relative foster parents receive fewer services from child welfare agencies than do regular foster parents (Berrick, Barth, and Needell 1994; U.S. Department of Health and Human Services 2000; Ehrle and Geen 2002). Because situations requiring the placement of a child often unfold rapidly, they often receive no formal training about the responsibilities of fostering, or about what the foster parent has a right to expect from the agency. Because relatives usually know the child, the agency tends to spend less time preparing them to meet the needs of the particular child. Visits from a caseworker both support and supervise a placement. Studies show that kinship foster homes receive fewer visits from child welfare workers than do regular foster homes (Ehrle and Geen 2002). Despite this lack of services, placements in kinship foster homes are stable (Testa, Bruhn, and Helton 2010).

Because of family relationships, children in kinship foster care are likely to maintain more frequent contact with parents than children in regular foster care, though parental contact can become quite infrequent in a long placement (Denby 2011). This contact, unless well supervised, could be problematic, depending on the reasons for separation of child and parents. It is also a tremendous comfort to children. Family relations can be complex, and relatives may need help in thinking about how to regulate and supervise visits.

The social worker has to assess many factors—including the competence of the foster parents, their knowledge of the child and comfort with his or her behaviors, the degree of emotional and/or behavioral disturbance the child exhibits, the relationship between the foster family and the child's own parents, and the degree of stress caused in the household by the addition of the foster child—and then plan supervision and support activities accordingly.

It must be recognized that the child is still within the family. The agency must avoid being needlessly intrusive, respecting the family's desire to make decisions about its own members. The child welfare worker needs to recognize that these caregivers have responded to a family crisis by taking in a child and that they may experience intense feelings of "disappointment, helplessness, uncertainty, grief, loss, guilt, obligation, pride, or anxiety" (Jackson 1999:108). These feelings are different from those of nonrelated foster parents; support must also differ.

Though state policies may require that caseworkers provide the same level of support and supervision to kinship foster parents that they do to regular foster parents, research cited earlier in the chapter has consistently shown that kinship foster homes have less contact with the child welfare worker than do regular foster parents. Given the complexity of their task, the limited introduction they often receive to the agency and to the issues of the child they are to foster, and their often limited access to foster parent training, it is probable they should receive more support.

Kinship foster homes are most common among communities of color, where extended families are traditionally involved in the rearing of children. This suggests that assessment, training, and support activities need to be tailored to the practices of these communities, recognizing their traditions and the natural helping networks that exist. The fact that kinship foster homes receive fewer services than do non-kin foster homes must be viewed with the suspicion that it may be an example of racism in the child welfare system (Roberts 2002).

Outcomes

Originally, doubts were expressed that a family that had produced parents so troubled that their children had to be removed from their care would be optimal as foster parents. However, experience has removed those doubts.

Safety When kinship foster parents first began to be used, safety concerns were raised. One concern was that relatives might not have the knowledge or resources to care for children well. The Child Welfare League raised this issue and noted the importance of policies that would ensure frequent worker visits to supervise and support these placements (Child Welfare League of America 1994). Licensing standards and training are also important: the Children's Bureau has urged that licensing standards be the same for kin and non-kin families (Holder et al. 2003). Among the licensing requirements mandated by the Adoption and Safe Families Act are a federal background check for abuse or neglect and a criminal history records check.

Studies of maltreatment in foster care do not find any more problems in kinship foster homes than in regular foster homes. According to a 1999 study done in Illinois, the incidence of child maltreatment in relative foster homes, at 19 per 1,000, is lower than that in most other types of out-of-home care (Poertner, Bussey, and Fluke 1999); other researchers have found little difference between relative and regular foster homes (Barth et al. 2007). When maltreatment does occur, in both types of foster care, the situation is complex and difficult to understand. Often it is associated with foster parent inability to help the child modify extremely difficult behavior (Holder et al. 2003).

One particular safety concern that has been raised is the difficulty of relatives in regulating and supervising the visits of parents. Though some parents do threaten the safety of their children, most do not. The emphasis in foster care has been more on enhancing visiting opportunities of parents to preserve the connection for the child. Relative foster parents are often accustomed to the parents, as relatives, being in and out of their homes. Informal visiting patterns often develop. When there is a problem, the agency has the authority to regulate visits and usually will work cooperatively with the foster parents to do this.

Well-Being Kinship foster care should help to lessen trauma of placement into foster care, and indeed NSCAW data show that informal kinship arrangements are often used during the assessment phase of a case to provide safety without excessive trauma to children (Testa, Bruhn, and Helton 2010). Children often know the family with whom they are going to live and thus do not experience the fear of the unknown. Kin families are culturally similar to the families the children come from, so children do not have to learn entirely new ways of

living. Generally, parents have a good deal of rather informal access to children placed with relatives, and frequent visits from parents have been associated with stronger identification with family (McDonald et al. 1996). Children's access to "bonding social capital"—a measure of the senses of closeness and protection that children feel to their caregiver—is greater for children in kinship foster care than for children in non-kin foster care (Testa, Bruhn, and Helton 2010). Additionally, children tend to report that they are happy in kinship foster homes (Wilson and Conroy 1999; Conway and Hutson 2007).

The outcomes for children raised in regular foster care are troubling; they are reviewed in the following chapter on foster care. There is no definitive information on whether children raised in kinship foster homes fare better (Geen 2004). Children in kinship care experience fewer placement changes, are more likely to be placed with their siblings, and report more positive feelings toward caregivers (Conway and Hutson 2007; Testa, Bruhn, and Helton 2010). Kinship care respects the child's cultural and family traditions. Kinship foster care enhances the child's family support system so that as the child grows into adulthood, family support will be available. With this stability and continued surround by family, theory would suggest that outcomes will be more positive than those for traditional foster care.

As is true for many foster parents, this foster parent has had little voice in the long-term planning for the child in her care; in box 5.4, she voices her confusion and distress.

BOX 5.4

"I have had her for quite some time, and there are attachments there. And there are concerns. I have had many misgivings about having her go home, and worry spells. So how do I neutralize and detach and let go my own self, and encourage the fruitful relationship between she and her mom, when I am still in disagreement or discord with how that family unit operates. So I've really had to learn, and [the therapist] has really, she is a wonderful woman, we work on different skills.

"You want to help the kid, but I've gotten to the point where I don't feel like I can deal with my sister or [the child welfare agency] together. They are on the same pathway of reunification. I really feel that they always have been, and that's great. But after four years the kid needs to, be it good or bad, have some permanency."

Permanency Though placements with relatives tend to be long and to be stable, they do not have the legal protections of a permanent placement. About half of children in foster care are eventually reunited with their parents (U.S. Department of Health and Human Services 2012a). Early studies found a lower reunification rate for children in kinship care (Dubowitz, Feigelman, and Zuravin 1993; Berrick, Barth, and Needell 1994). Parents often have considerable access to their children when they are placed with relatives, and because they are with "family," returning children to a more problematic life with their original parents may not seem very important to the agency.

When children cannot return home, either adoption or guardianship offer routes to permanency. Adoption has been the outcome that agencies have traditionally pursued. Adoption subsidies have long been established, so that in many states foster parents that adopt will have a monthly stipend almost as great as their former foster care payment. This also applies to kinship foster parents who decide to adopt. There has been very little discussion of the appropriateness of kin foster parents as adoptive parents—it seems to be assumed that as they are family, and wish to adopt, it is a good solution, for adoption by relatives provides permanency and maintains continuity with family.[11]

Nevertheless, some relatives are reluctant to take this path, both because of the upset to family relations that it will cause and because of a reluctance to take on full responsibility for a child—perhaps due to age or perhaps

because they feel the need to access services and have agency guidance as the child grows (Denby 2011). And some older adolescents do not wish to be adopted.

A path to permanency that is increasingly opening for relative foster parents is legal guardianship. Guardianship establishes a legal relationship between guardians and child and allows foster parents to take responsibility for a child and make decisions about education and health needs. Though regular caseworker supervision and support ends with guardianship, payments for services such as mental health counseling may continue, and medical insurance (Medicaid) continues. Increasingly, states are using subsidies to help relatives assume guardianship.

From 1996 to 2002, eleven states experimented with guardianship programs using Title IV-E waivers. The research designs differed, but all involved some type of comparison to assess the impact of subsidized guardianship for kin foster parents. Subsidies varied; many were less than adoption subsidies or foster care payments. Despite this disincentive, the waiver studies tended to show that subsidized guardianship increased permanence, and the Illinois study showed that this increase happened without decreasing adoptions (Hill 2009). The 2008 Fostering Connections to Success and Increasing Adoptions Act permits use of federal funds for kinship guardianship stipends. The act stipulates that for licensed foster homes, the guardianship rates will be the same as the foster care payment.

Conclusion

Certainly, kinship foster care has grown rapidly, both in response to the child welfare system's emphasis on preserving families and in response to the shortage of foster homes. It demands a new way of thinking about families and about foster care. The complexities of familial relationships can be unsettling, often create mini-crises in the placement, and may make adoption unlikely. Relative foster parents have undertaken a difficult task and need more support and services from agencies than is commonly provided. But for children, placement with a known relative eases the trauma of separation, makes visits from former caretakers more likely, and keeps them within their original extended family. These tend to be long and stable placements, and new federal support for subsidized guardianship enhance the possibility of providing legal supports to a permanent home.

Critical Issue: Paths to Evidence-Informed Practice and Policy in Child Welfare

Evidence-informed practice could have been explored as part of any of the chapters of this book. It seemed to fit rather well here. Family preservation has been studied, and it has not been demonstrated that it prevents foster care—yet it follows principles that practice wisdom has deemed effective, and families report that it is helpful. The early childhood learning programs and parent-training programs, reviewed in the last chapter, have, in contrast, demonstrated their effectiveness in improving parenting skills in quite rigorous experimental design research. Foster care, which is the subject of the following chapters, has not been subjected to experimental design research, but knowledge has been gained mostly through comparisons of groups, through qualitative research, and recently through use of administrative databases. Evidence-informed practice and policy is a complex issue to explore. It is, however, important that methods of work with these troubled families be the most effective methods. Thus, evidence-informed practice is important to families and children now and to the future of child welfare.

The complexity begins with the terminology, used differently by different authors. *Evidence-based practice* has become a common term. Eileen Gambrill, who has been responsible for much of the writing about evidence-based (evidence-informed) practice in social work, defines it as practice using the clinical expertise

of the social worker, occurring at the intersection of the best research evidence, the clinical characteristics and circumstances of the client, and client preferences and actions (Gambrill 2008:52). The best research evidence generally means evidence about an intervention that has proved effective in well-designed research. Increasingly, the term *evidence-informed practice* is being used, and in its most common usage it seems to conform to Gambrill's definition. One also finds the term *research-informed practice* in use.

Evidence-informed practice has become an increasingly important concept in social work and in child welfare. Caseworkers needing to make a decision want to know what information exists. Policy makers and those who fund programs want to know "what works." A public impatient with continuing high numbers of abused and neglected children wants to see effective prevention services in place. A public impatient with reports of re-abuse of children, impatient with the high cost of out-of-home care, and impatient with the litany of mistakes reported on the front pages of the newspapers is demanding that those that work in child welfare discover effective ways of treating families and children. And the federal government is increasingly directing funding toward interventions whose efficacy has been demonstrated in solid research.

The Basis for Decision Making

Child welfare policy and practice have long been guided by the ethics of the social work profession, by the theoretical base of practice, and by the "practice wisdom" generated through experience. In the past ten years, a demand that there be research-based evidence of practice effectiveness has been added. Decision making about appropriate interventions should shift from decisions based on authority (my supervisor/consultant/professor/important author says it is the best way) or imperfect experience (this is what I did with a client a few weeks ago with the same problems, and I think it helped) to those informed by careful research. This evidence has developed slowly, and debate about the nature and quality of evidence needs to continue.

Evidence-based practice is "designed to help practitioners link, evidentiary, ethical and application issues" (Gambrill 2008:52). The social work code of ethics calls on practitioners to be knowledgeable about various interventions and to share that knowledge with the client as they together evaluate the wisdom of an intervention.[12] There is recognition in these definitions that the intervention chosen relies on the best empirical evidence, but also on the availability of resources in the community and on client preferences. Practice is thus not based solely on empirical evidence, but the empirical evidence becomes one element informing practice decisions. The National Association of Social Workers has a web page that contains some thoughtful material about the application of evidence-based practice to social work, and resources for to help workers find and use evidence-informed practice (National Association of Social Workers 2008).

Quantitative Research

The preferred way to demonstrate that a treatment approach works is to specify measurable goals, put the intervention to be tested into a practice manual (so that it will be used as intended), separate the participants in the research into two nearly identical groups, and then contrast the results for one group that receives the treatment (an experimental group) with another that does not (a control group). The best evidence for practice effectiveness, often called the "gold standard," stems from either two randomized controlled clinical trials or a meta-analysis—a technique that combines the research on a topic into one large study with many participants. A meta-analysis makes it possible to explore the effect of specific research designs on the findings. The technique is complex (Littell 2008).[13] That basic scheme has been successfully used in many fields; it is,

for example, the way that new drugs are tested for effectiveness.

Experimental Design in Child Welfare The process of carrying out experimental design research sounds so simple but is difficult to put into place in child welfare settings. Ethical issues often limit the possibilities of developing randomly assigned experimental and control groups. Complex trauma, co-occurring conditions, and the multiplicity of difficulties some families face as they arrive at child welfare's doorstep mean that single interventions demonstrated to fit single problems are often insufficient. These difficulties have led to a great deal of research that may provide valuable information but is less rigorous. Two groups that receive different interventions may be compared, but without random assignment it is not certain that it is the intervention that was responsible for any differences found. There may be a single clinical trial with an experimental design, but until it is replicated, it is possible that the sample is in some way unique.

Another difficulty with experimental designs is specifying exactly what the intervention is that is being tested. If the question involves an intervention such as intensive family preservation services, the best one can do is to specify the broad outlines such as time frames, frequency of worker contact, and the philosophy of empowering the client and providing services the client wants, for the specific problems of the families are varied, as are the services available. A less complex intervention, such as a parent-training program, can be outlined with greater specificity. If, however, one does not draw parameters around the intervention, nobody knows what was tested.[14] And in actual practice, an intervention cannot be delivered in a specific way (as a manual might suggest) if it ignores the culture and particular circumstances of the client.

Specifying the goals and measuring them can be complex. (Specifying goals is, however, a wonderful way of being sure that goals are consistent with the mission of child welfare and with ethical practice.) Measurement is even more complex. If the goal is prevention, as in family preservation research with a goal of preventing foster care, one must find a way to measure the absence of an event. Many goals are amorphous, such as increasing effective parenting. Many measurements are available, from simple observation to elaborate scales, but questions can be raised about the reliability and validity of many measures, particularly those purporting to measure complex outcomes.

Ethics complicates separating families or children into experimental and control groups; if you have reason to believe that an intervention will help, is it ethical to deny it to the control group? A common answer is to give a control group "services as usual," but the reason a new approach is being tried is that "usual" services are producing poor results. Often, too, there is talk among practitioners and hence "contamination," so that one service begins to have elements of another. Or practitioners do not deliver the service exactly as they were expected to, because families and children often do not respond as expected. Ethics also demands that practitioners inform clients of the evidence that a given intervention is effective; clients have a right to participate in decision making about their own care.

And how do you get two groups of families or children that are similar enough that you can compare them? You can use random assignment, so that there is no bias marking either the control or experimental group. You can match them on qualities that you think are important. You can select both groups from the same low-income groups, using only single-parent families, and only families in which the parents have less than a high school education. But what do you do about the discovery that one group has a higher percentage of children with disabilities or that one group has a higher percentage that becomes homeless? It can be managed, but it is not easy to establish an adequate control group. There are a great many variables that impact children and families.

And finally, if the goal is prevention, how do you determine the absence of an event, particularly if it is an event that is not going to happen very often in either the experimental or control group? That, of course, was the difficulty that researchers faced in evaluating the effectiveness of the intensive family preservation programs.

Effective Interventions These are the issues that have made the use of interventions that have demonstrated effectiveness less available in child welfare than in some other areas of social work. In the past chapter, we reviewed both home-visiting programs and parent-training programs that have demonstrated effectiveness. But as attention turns to families in crisis, who have entered the child welfare system, there is less evidence-based practice available. And when we begin to discuss out-of-home care, there is even less work based on experimental designs, though there are treatment protocols for youth in both treatment foster care and residential care that have been rigorously tested.

The studies that attempted to determine whether family preservation actually did prevent placement, reviewed earlier in the chapter, used experimental and control groups (Schuerman, Rzepnicki, and Littell 1994; McCroskey and Meezan 1997). As it was not ethically (or legally) possible to create a control group by denying services to a group of families who had abused or neglected their children, the control group was created by giving some families the supportive services currently available in the child welfare system, while the experimental group got family preservation services. However, foster home placement proved to be a relatively rare event, even with targeted high-risk populations—it was rare in both control and experimental groups. Thus, a very small percentage of children in either group were placed in foster care, and the difference was not big enough to be statistically significant.[15]

Careful analysis of the findings of the various studies yielded information about how to make these services more effective. The best predictor of children remaining at home was the engagement of families, and families reported that early provision of concrete resources encouraged engagement. Families were more likely to engage in family preservation services and avoid child placement when the problem was acute rather than chronic. Thus, information accumulates.

Family preservation services were valued by the families, they fit the value system of social work, and workers saw changes and improvement in the families with whom they worked. Indeed, the outcome studies identified improvements in family functioning among those who had received family preservation services—as well as identifying those families for whom the services were most useful. The intervention is apparently effective for some families in enhancing family well-being, though it cannot be shown to prevent foster care placement.

Experimental designs have been used to develop treatment protocols for children with serious emotional and behavioral problems in treatment foster care and in residential care (see the following chapters). The most successful in helping children control their behavior in the foster home or institution and transfer that learning to the community have been behavioral modification programs that emphasize positive rewards. Negative consequences for unacceptable behavior help youth learn, but positive rewards seem to help children build the self-esteem and self-confidence to try these new positive behaviors consistently. These protocols are very explicit and can be taught to foster parents and residential staff and can be fairly easily implemented as designed. This specificity of intervention ensures that the experimental design is testing what it is supposed to be testing.

Group Comparison Designs If experimental design is not possible, comparisons of two or more groups can yield useful information. Because it is so difficult to create experimental and control groups through random

assignment, much child welfare knowledge is based on comparisons of groups that have similarities but differ in some factor of interest.

Our federal system offers a major advantage in the development of new programs. When states use differing approaches to a problem, comparisons of outcomes can advance knowledge. These are group comparisons, on a large scale. The Children's Bureau used this approach when it encouraged states to test differing subsidy amounts in evaluating subsidized guardianship (the program to make it possible for relative foster parents, for whom adoption was not an option, to consider guardianship).

Hill describes the studies demonstrating that subsidized guardianship improved permanency outcomes for older youth in foster care:

> There were wide differences among the states regarding research design, sample sizes, and procedures for assigning cases. Four of the states—Illinois, Maryland, Montana, and New Mexico—used random assignment designs that included experimental treatment and control groups. North Carolina and Oregon conducted a descriptive analysis of their subsidized guardianship programs and examined child welfare outcomes at an aggregate, county-wide level. New Mexico used a comparison group for the small Tribal component of its program and Delaware relied on a pretest and posttest model to examine differences in outcomes before and after implementation of the waiver. Illinois was the only state to provide rigorous evidence that subsidized guardianship improves permanency outcomes for children. (Hill 2009:164–65)

All the studies found that youth did well in kinship foster homes that achieved guardianship. It was the Illinois study that had the greatest impact on the policy debate that led to the passage of the Fostering Connections to Success Act that provided federal funds for subsidized guardianship.

Given the variations in laws regarding child welfare among the fifty states, comparisons among states is an approach often used. International comparisons are also useful.

Cost-Benefit Analysis In public funding of anything, there is a demand that resources be used thoughtfully and effectively. An intervention that will conserve resources is always welcome. Services to prevent poor outcomes are welcome because the cost of prevention is so much less than the cost of remediation. That was, of course, the original impetus behind the family preservation models—if foster care could be prevented, the state would save the large sums it spends on this service, and the much lesser amount spent on intensive services would be justified. When it could not be demonstrated that intensive family preservation services prevented foster care placement, these immediate cost savings could not be demonstrated, though other benefits of family preservation may prevent long-term costs. The cost-benefit analysis of the Nurse-Family Partnership program, briefly noted in chapter 4, was used to demonstrate how the minimal community investment in programs for young children could save the community a great deal of money by preventing educational failure, delinquency, and similar poor outcomes.[16]

Qualitative Research

Qualitative research offers much information to social work. It is the method that dominated social work research early in the twentieth century, when knowledge was built through case studies of individuals, families, and communities, as illustrated in the story of the investigation of poverty in chapter 1 of this book. Because it is holistic, viewing the person in the situation, it is a good fit to the questions that social work practitioners and policy makers ask. It acknowledges systems and the feedback loops of systems; it is not linear. It is a complex field of research with many methodologies designed to enhance its observations and suppress biases of the researcher, and it has considerable sophistication.

Qualitative research is good at getting at the meaning of events, helping us understand what is happening. However, it is difficult to establish the validity of the interpretation of meanings, and generalizing beyond the particular subject studied has always been a difficulty for qualitative research. It is not good at identifying linear cause-effect relationships, and the question most often being asked is "Does this intervention produce the expected outcome?" The dilemma of social work research is "that qualitative research is both necessary for a scientific understanding of people's experiences and, for now, inadequately valid to convincingly provide that understanding" (Wakefield 1995:17). Qualitative research should not be ignored, for it is one of the sources of empirical knowledge that can inform social work.

Qualitative studies in child welfare have been particularly useful in gaining the view of children and parents about the services they are offered. Children's perspectives on foster care received very little attention until the mid-1990s, when qualitative studies began to display their ideas (Johnson, Yoken, and Voss 1995; Wilson and Conroy 1999).[17] Qualitative studies can reveal subtle and important data; in the next chapter, we refer to a study that furthered understanding of how mothers feel when accused of neglect (Sykes 2011), important information that would have impact on the clinical work with a mother, as well as on the interventions selected.

Large Data Systems

The analyses that large data systems make possible represent a growing resource for evidence-informed practice. With the advent of computers and their use for the collection and management of data, large amounts of administrative data are increasingly becoming available. After years of development, administrative data are now available for all fifty states through the State Automated Child Welfare Information System (SACWIS) of the Children's Bureau, containing AFCARS and the National Child Abuse and Neglect Data System (NCANDS). These data provide the numbers descriptive of protective services and out-of-home care. In addition, the outcomes generated by the CFSRs are being published, with emphasis on changes over time. Data from these sources make it possible to see some of the impact of new policy or legislation—they have been frequently used in this way in this book. State-by-state data are increasingly available online. With this data, it is possible to see the variability among the states, and websites are increasingly using these data to provide maps illustrating the variability.

Large data sets developed for one purpose can also be used to answer related child welfare questions. For example, The Longitudinal Study of Adolescent Health (AddHealth) is a study that has followed a nationally representative sample since the 1994–1995 school year, with a focus on health issues. Selected data from this study was used as a comparison group by Courtney and colleagues as they studied the transition of youth from foster care into adult years (Courtney et al. 2011). This is extensively reported in chapter 9. This study was strengthened because the database contained material about children who had not been in foster care, so it was possible to compare the two groups of youth and discover differences associated with the foster care experience.

Big data sets that will be useful for future comparisons, in addition to the information they are independently providing, are also being built by ongoing studies. A data set is emerging from a study of foster children in three states in the Northwest (Pecora et al. 2010). Chapin Hall at the University of Chicago is building the Multistate Foster Care Data Archive, a longitudinal data set that includes data on approximately 1.3 million foster children in 12 states (Wulczyn 2005). The Office of Administration for Children and Families has sponsored the National Survey of Child and Adolescent Well-Being, a national probability sample following of children and families who have been investigated by protective services (Dolan et al. 2012).

The reader will find information from these and other large data sets used throughout the child welfare literature, as it has been throughout this book.

Making Sense of It All

The number of research studies available and the difficulties of selecting among them can make the search for research daunting for the practitioner. The California Evidence Based Clearinghouse for Child Welfare (www.cebc4cw.org) is a valuable resource for the child welfare community. It is a searchable website that allows one to search for research on the specific topic of interest, and an incredible number of topics relating to child welfare practice are presented. It has a "grading" system that allows the user to use the expertise of researchers in finding the "best" evidence. It also identifies areas of practice where there is substantial empirical data and areas with very little research. The website is interactive and is remarkably easy to use.

Putting together the information generated by multiple research studies over time is a difficult task, yet one that is necessary if the worker is to benefit from research-generated knowledge. One mechanism that we are all familiar with, and that has been used throughout this book, is a literature review. However, when dealing with research findings, if they are put together in a more systematic way, the quality of knowledge is improved. The steps in this process are similar to the steps in any research and are demanding, consuming time and resources. Two international consortiums, the Cochrane Collaboration (www.cochrane.org) and the Campbell Collaboration (http://campbell.gse.upenn.edu), have developed protocols for this process and produce reviews, or meta-analyses, on specific topics.

Toward a Broad Interpretation

Protective services, and all child welfare, will benefit greatly from the research now under way. With increasing understanding of the neurologic and social impact of various family and community conditions, the way is opening for targeted interventions that can be demonstrated to prevent undesirable outcomes—which should not distract us from what we already know through the study of trends and patterns that show consistency across time and place. This is "practice wisdom." Nor should we ignore theory, which informs both practice and policy and outlines the important issues for further empirical exploration. Clinical skills will remain critical, both in developing precise understanding of the nature of the presenting problems (which precedes selecting an intervention that will be effective) and in engaging the client(s) in helping figure out what is needed. The mantra of evidence-informed practice—that the research base is but one of the elements guiding the work of the practitioner—is important.

This is particularly important as evidence-informed practice is used in diverse cultures. Evidence-based practice was developed primarily in academic settings and then marketed to the practice community. As part of the push to increase the use of empirically based interventions, there is often an incentive of funding for an intervention that has been found effective.[18] However, Aisenberg (2008) notes that the evidence base for many of the "gold standard" interventions includes few participants who are non-white. The cultural context of communities of color, which have their own traditions and knowledge, and do not privilege "scientific" knowledge, has not been taken into account in prescribing the use of these interventions. Furthermore, the "adaptation" to different cultures suggested in the literature does not fit with the demand that there be fidelity to the tested intervention. These are all arguments that suggest that we need to work with the broader concept of evidence-informed practice—where the scientific evidence is one factor taken into account.

On another level, we know about the association of poverty with almost all the problems that bring families to child welfare services: Jane Addams first observed this, and practitioners

have found it to be so. Pelton notes that not everything needs research; the provision of concrete services improves the situation of the individual who needs them (Pelton 2008). Social work values have grown, in part, from consistent observation over time of the difficulties of economic inequality. These values and the knowledge we have demand advocacy for major changes in our economic structure, our health care system, our schools, and our prisons. This would be evidence-informed policy advocacy, though the evidence is not that of formal research design.

The National Association of Social Workers (NASW) in 2008 published a research webpage in which they noted that "Consumers and professionals are important stakeholders in developing research agenda so research moves from effectiveness and efficacy to intervention research and takes into account real-world issues of resources, access, consumer and organizational cultural, and organizational climate." This is the movement that is taking place, and the caveats discussed in the above paragraphs are evidence of that movement. As formal empirical evidence accumulates, we can test existing data and use it in new ways. The body of knowledge continues to grow, and the responsible child welfare worker keeps abreast of it and uses it.

Conclusion

In the past twenty years, there has been major investment in keeping children with their own families, even when the risk of remaining in those homes is high enough for foster care to be considered. Intensive family preservation services and community-based services will provide sufficient family support to enable some children to remain with their original families. Kinship foster care will enable others to remain within their extended families.

Intensive family preservation services help families manage a crisis that has threatened the integrity of the family. They offer an array of services and intensive case management to meet a range of needs identified by the families. They have been controversial because sometimes they do leave children in relatively high-risk situations. Though it has not been demonstrated that they prevent placement in foster care, families report improved functioning and value the services.

One of the important contributions of the family preservation movement is its affirmation of the importance of families and the philosophical stance that parents are concerned about their children and want to be good parents. Through family preservation services, the voices of parents—so crucial to planning and decision making about their children—have been brought into the process and into the consciousness of professionals.

Kinship foster care, which began with many concerns about the capacity of relatives to care for children, has become a major resource of the system. Relative placements have proved to be stable and to offer emotional continuity to children. There is some tendency for social workers to believe that relatives know the children and will continue to care for them out of duty, and thus to offer fewer supports. Thus these foster parents, who take in children with many needs, receive less help from the child welfare system than do nonrelative foster parents. Despite this, placements with relatives tend to be stable, and this continuity of care is critical to children as they recover from their earlier experiences.

In family preservation services, kinship foster care, and the many other child welfare programs and services described in this book, there is increasing interest on knowing "what works." Increasingly, child welfare decision making and interventions are being subjected to thoughtful and rigorous evaluation. The terms *evidence-based practice* and *evidence-informed practice* have, within the past ten years, moved from a marginal place in child welfare to a central dynamic. Some clearly defined programs have been rigorously enough tested through research relying on experimental designs that they are labeled "evidence-based" interventions.

However, this research methodology has not proved as useful for the larger, more complex interventions of child welfare practice. For these, additional methods of generating evidence are needed:

> The randomized control trial is a powerful research design for some purposes. It can establish the efficacy of selected components of practice, as has been shown by its use in the medical field, and its application to interventions that are conceptually neat, with a clear causal relationship to the outcome of interest. However, when causal connections are more diffuse, intertwined, and otherwise difficult to establish, we need not give up on assessing effectiveness. Rather, we must agree that the value of many kinds of interventions can be assessed, weighed, understood, and acted upon without having to be proven through experimental methods. (Schorr and Farrow 2011:ii)

Some of the evidence about the effectiveness of interventions or new programs will come from research that does not meet the rigor of experimental designs or from the richness of qualitative research that uses a different paradigm to provide information. Some comes from learning what the families and children want and need—this is a basic tenet of social work practice and has been a particular gift to child welfare from family preservation work. Some of the evidence comes from the experience, practice wisdom, and ethical stance of the practitioner or policy maker.

Evaluating the quality of the research evidence is probably easier than evaluating the quality of other types of evidence, but it feels foreign to many who have an educational background that has emphasized human services. Hopefully, the final section of this chapter has shown how this evidence is used in many of the facets of child welfare work that we are exploring in this book. And hopefully it has introduced the idea that an ethical practitioner will review all of the available evidence before deciding on a course of action.

NOTES

1. Mary Beth Seader quotes from some of these in her chapter "Do Services to Preserve the Family Place Children at Risk" in *Controversial Issues in Child Welfare*, edited by Eileen Gambrill and Theodore Stein: 59–72. (Needham Heights, MA: Allyn and Bacon, 1994).
2. The Edna McConnell Clark Foundation, which provided demonstration funding for many new Homebuilders programs, vigorously promoted the model as a revolutionary new way to work successfully with abusing and neglecting families while reducing the cost of maintaining children in foster care.
3. The original model was developed by Families, Inc., in Iowa. In cooperation with the University of Iowa School of Social Work and the University of Iowa Institute of Child Behavior and Development, Families, Inc., was an original sponsor of the Clearinghouse for Home-Based Services, which, with a grant from the Children's Bureau, became the National Resource Center on Family-Based Services in 1981. A yearly conference has drawn increasing numbers of participants and has been important in the development of family preservation services. The presence and voice of families themselves is a key aspect of that conference.
4. For discussion of these programs designed to impact the community, see Daro and Dodge (2009).
5. Families First, conducted in Illinois in 1989–1992 and the largest randomized study of family preservation programs, found that the risk of placement in the control group was 7 percent in the first month of services and after one year about 21 percent; in the experimental group, the risk was 5 percent in the first month of services and 23 percent after one year. The differences are not statistically significant (Schuerman, Rzepnicki, and Littell 1994:230).
6. This may be a positive finding. It could be that more intensive contact with the families who received family preservation services resulted in the detection of real threats to children's safety and thus to subsequent placements.
7. Throughout this discussion, the reader will find comparisons to "regular foster care" or "traditional foster care." Traditionally, when children needed placement outside the home, they have been placed with foster homes selected, trained, and supervised by the child welfare agency. These

foster parents are not relatives and usually do not have prior knowledge of the children or family. This foster care is examined at length in the following chapter.

8. The children we followed through a protective experience in chapter 3 spent a brief time in an informal foster placement with their grandparents.
9. In 2002, about 16 percent of the children in the United States lived in households with incomes below the poverty line.
10. Noting that kinship providers felt obligation, and as relatives had little control over the children who entered their homes, Koh (2010) in a comparison of permanency outcomes for children in kinship and in regular foster care suggested that the degree of emotional/behavioral difficulty of children in kinship foster care would suggest that fewer would adopt their foster children.
11. See a thoughtful chapter by Mark Testa (2008) for an exploration of the philosophy behind adoption and guardianship for children in foster care.
12. In the NASW Code of Ethics, see particularly sections 1.03 Informed Consent and 5.02 Evaluation and Research. The Code of Ethics is available at www.socialworkers.org/pubs/code/code/asp.
13. Reamer and Siegel (2010), in their discussion of finding and selecting empirically validated interventions in work with teens, present an excellent and understandable explanation of meta-analysis.
14. This was the difficulty with the first research review on the effectiveness of casework. Casework was so varied that it could be operationalized only as "an intervention preformed by a professionally trained caseworker" (Fischer 1973). The article, showing that casework had little effect, created much discussion, but the findings were explained away because "casework" was not better defined.
15. By now you feel that you are back in your research 101 class, and it is exactly the concepts learned there that are being applied in child welfare services.
16. A detailed cost-benefit analysis is contained in Richard McKenzie's *Rethinking Orphanages for the 21st Century* (Thousand Oaks, CA: Sage, 1999), in which the costs of foster care and institutional care are compared. Foster care is considerably less expensive, and some treatment foster care is showing good results, so that there is a preference for using foster care when possible. The cost analysis is attempting to show that institutions are not more costly than foster care if one (1) assigns an hourly wage for the hours the foster parent spends in being a foster parent and (2) considers only care, eliminating treatment costs. It is an interesting analysis, and it clearly demonstrates the minimal reimbursement that foster parents receive.
17. Children are being interviewed for the NSCAW data, and the interviews are being coded and presented as quantitative data. Children's rather surprising positive evaluations of their foster care experiences have emerged from these data. This is, perhaps, an illustration of qualitative research providing a foundation for later inquiry with a much larger sample.
18. For example, current stipulations for funding in Title IV-E waivers include the requirement that interventions be from a list of evidence-based interventions.

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6

Investment in Foster Care

"What's the matter, Eeyore?"
"Nothing, Christopher Robin. Nothing important. I suppose you haven't seen a house or whatnot anywhere about?"
"What sort of a house?"
"Just a house."
"Who lives there?"
"I do. At least I thought I did. But I suppose I don't. After all, we can't all have houses."
—A. Milne, *The House at Pooh Corner*

At the heart of many difficulties of the child welfare system are the difficulties of the foster care system: a shortage of foster homes, questions about the quality of care children are getting in some foster homes, the system's inability or unwillingness to provide needed support services to foster parents, and, above all, uncertainty about the function of foster care within the child welfare system.

Demographic changes in the second half of the twentieth century have resulted in a shortage of foster homes. With more women in the workforce and more single-parent families, there are fewer families who wish to serve as foster families for children. The shortage of foster homes has led to unacceptable compromises in foster care practice—compromises in the assessment and supervision of homes, in matching the needs of children with the capacities of foster homes, and in deciding how many children should be placed in a given foster home. As a result, children are too often placed in inappropriate homes, too often moved, and too often damaged by the foster care experience.

One approach to the shortage has been to try to limit the number of children who need foster care. Major policy thrusts have included use of family preservation services, increased placement of children with relatives for fostering, and emphasis on shortening the children's stays in foster care, either through family reunification or adoption. Explicit federal legislation, including the Adoption and Safe Families Act (ASFA) requirements for periodic case review and the provisions for terminating parental rights, has also been directed at reducing the need for foster care. These efforts have resulted in a significant reduction of the numbers of children in foster care, with 100,000 fewer children in care in September 2011 than there were in September 2000. However, the number of children needing care still exceeds the capacity of the foster care system. Until the network of basic family support programs is better developed and funded, the need for foster care will remain.

This chapter begins with a brief look at the history of out-of-home care. The reader will note themes of the needs of children, as perceived at that time, interplay with concerns about children becoming economically self-sufficient, and questions about the moral character of the homes of the poor. This history also, sadly, reflects a continuing reluctance of communities to be generous in meeting the needs of children. The chapter continues by developing a picture of current foster care, both a statistical description and an exploration of the experience of foster care. In the last section, the voice of foster parents is heard as they tell us what they need.

Historical Perspective

Throughout the history of the United States—as in any society—there have been children who have needed care outside their own homes. Until the mid-nineteenth century, children commonly became homeless upon the death of their parents. Diseases claimed numerous lives; many women died in childbirth; the perils of Western settlement and the hazardous conditions of early industry left children without parents. Other children depended on the community for care because their families could not afford to house, feed, and clothe them or because their families neglected them.[1]

Congregate Care

The Almshouse In the eighteenth and early nineteenth centuries, the almshouse was the common institutional setting for any member of society who could not live independently. There the poor, the mentally ill, and young children lived together. Conditions could be frightful. By the mid-1800s, it was recognized that these large, mixed institutions were inappropriate for children.

> The high death rate, the outbreaks of contagious disease, the incompetent staff, and the generally neglected and unhappy condition of the children reported by individuals and special committees in one state after another led to the demand that this method of caring for dependent children be abandoned. Reform came slowly in view of the evidence of the serious conditions in the almshouses, because public funds had been invested in land and buildings and because of the fatal ease with which children and families could be placed in an almshouse. Moreover, as the number of children in almshouses was large, the problem of what to do with them if this form of care were abandoned was one not easily solved. (Abbott 1938b:7)

Orphanages Not until the middle of the nineteenth century were orphanages common enough to begin to replace almshouses for the care of children. Many were founded in response to crises. For example, the first orphanage in the United States was opened in New Orleans in 1727 by the Ursuline Sisters to care for children orphaned after the Natchez Indian massacre. The Chicago Home for Unfortunates (later renamed the Home for Little Wanderers) was founded to care for children orphaned by a cholera epidemic. The Parry Center in Portland, Oregon, was founded to care for the children whose parents died as the wagon trains came westward.

Children were valued for their potential contribution in a rapidly expanding country, and work was itself valued as morally important. Thus, the children should be taught a trade or the skills of farming or housework. So when children in an almshouse or an orphanage, or sometimes in a poor family, reached an age at which their labor was considered valuable, they were indentured. Through indenture, children were "bound over" to a family for a period of years, with the expectation that they would be given room, board, and some education, and would be taught a useful trade. The following excerpt from the notes of a town meeting in 1726 in Watertown, Massachusetts, is illustrative.

> There having been Some complaints made to the selectmen of some families in Said Town That are under very Neady and Suffering Circumstances. In which families there are Children of both sex's that are able to work in order to their Maintinance, and also of being sent to School and brought to the Publick worship of God; But through the willfulness, Negligence & Indulgence of their parents they are brought up in Idleness Ignorance & Ereligion, and are more Likely to prove a Trouble and Charge, then blessings in their Day & Generation if not timely prevented. . . . The Selectmen . . . do therefore order that the Town Clerk . . . give notice to Such Families or the parents of them that they forthwith take care to put out and Dispose of their Children to Such families where they may be taken good care of. . . . Also to Signify

> to all persons that Desire to take Servants or Apprentices to meet with the Selectmen at their Next Meeting. (Abbott 1938a:212–13)

Indenture, although it was based on a reasonable concept and sometimes worked to a young person's advantage, was unsupervised and open to abuses.[2] It persisted until, in the middle of the nineteenth century, industrialization took labor out of the home and moved it into the factory. The abolition of slavery was doubtless also a factor in the demise of indenture, for the contract that bound apprentice to master had some characteristics of involuntary servitude and might be considered unconstitutional under the post–Civil War amendments (Kadushin and Martin 1988).

An entry from the 1850 ledger of the Chicago Orphan Asylum, a more or less standard form required of parents who could not care for their children, illustrates the use of the orphanage and of indenture to care for the children of the poor as well as those who were orphaned.

> I, the subscriber, solicitous that my children, Christina Maria and Magnus Wilhelm shall receive the benefits and advantages of the Chicago Orphan Asylum, and the Trustees of said asylum being willing to receive and provide for them and also to place them out in a virtuous family until they are of age, agreeably to the provisions of the act of incorporation, and the rules and regulations of the said Asylum, provided I relinquish my children to them. I do, therefore, promise not to interfere in the management of them in any respect whatever, or visit them without their consent. And in consideration of their benevolence in thus rearing and providing for my children, I do relinquish all right and claim to them and their services, until they shall arrive of age. And I do engage that I will not ask or receive any compensation for the same, not take my children from, nor induce them to leave the families in which they may be placed by the Board of Trustees of the Asylum. Chicago, February 6, 1850. (McCausland 1976:23–24)

Foster Family Care

Foster Care Begins Orphanages sometimes placed children in homes for adoption, and homes were used for the indenture of older children; but the idea of foster care as an alternative that might replace the orphanage had its beginning on a large scale when, in 1855, Charles Loring Brace sent a trainload of children from the streets of New York to the farms of the West. Brace was appalled by the neglect and destitution of homeless children on New York's streets. He believed that a family, better than an orphanage, could provide a child a "normal" life and teach a child the skills required for a productive adulthood.[3] He was also aware of the consequences to society of neglecting its children:

> It should be remembered that there are no dangers to the value of property, or to the permanency of our institutions, so great as those from the existence of such a class of vagabond, ignorant, ungoverned children. This "dangerous class" has not begun to show itself, as it will in eight or ten years, when these boys and girls are matured. Those who were too negligent, or too selfish, to notice them as children, will be fully aware of them as men. They will vote—they will have the same rights as we ourselves, though they have grown up ignorant of moral principle. . . . They will poison society. They will perhaps be embittered at the wealth and luxuries they never share. Then let society beware. (Brace 1872:321–22)

In the farming economy of the West, children's labor was needed on the farms, so foster homes were readily available. Brace's organization, the Children's Aid Society, collected children from the streets of New York City and from the city's institutions. Some were orphans; if a parent was living, an attempt was made to get parental consent for the child's placement in a farm home. Large groups of these children would arrive in a community by train, and families would select the ones they wanted to take into their homes. The placement of the children was overseen by

a committee of respected community members, but it may have been awkward for these citizens to object to a questionable placement. An early child welfare worker, Dr. Hastings Hart, described the placement procedure in a report to the National Conference of Charities and Corrections in 1894:

> It was surprising how many happy selections were made under such circumstances. In a little more than three hours nearly all those forty children were disposed of. Some who had not previously applied selected children. There was little time for consultation, and refusal would be embarrassing, and I know that the committee consented to some assignments against their better judgment . . . while the younger children are taken from motives of benevolence and are uniformly well treated, the older ones are, in the majority of cases, taken from motives of profit, and are expected to earn their way from the start. (Kadushin and Martin 1988:348)

Brace's program drew criticism because children were sent over such vast distances and because many children of Catholic immigrants were placed into Protestant homes.[4] Questions were also raised about inadequate supervision of the selection and placement of the children. Accused of sending children into unknown homes where they might be abused or neglected, Brace sent his own investigators to follow up on his placements. The reports were optimistic:

> The general results are similar. The boys and girls who were sent out when under fourteen are often heard from, and succeed remarkably well. In hundreds of instances, they cannot be distinguished from the young men and women natives in the villages. Large numbers have farms of their own, and are prospering reasonably well in the world. Some are in the professions, some are mechanics or shop-keepers, the girls are generally well married. . . . With the larger boys, exact results are more difficult to attain, as they leave their places frequently. Some few seem to drift into the Western cities and take up street trades again. Very few, indeed, get back to New York. The great mass become honest producers on the Western soil. (Brace 1872:241–42)

These reports were never fully trusted; unfortunately, there was no independent investigation at the time. The orphan trains continued until 1929, by which time 31,081 children had been placed by the Children's Aid Society (Costin, Bell, and Downs 1991). In the 1980s, interviews with about two hundred adults who had come West on the trains revealed the variety of experiences that one might expect. The uncertainty of the train trip and the hope that they could remain with siblings were common themes among those interviewed. They recalled continuing to wonder about, and to long for, their original families. Their experiences in their placements were mixed, ranging from being exploited and abused as laborers to feeling like part of the family and partaking of its joys and troubles. Some had several placements before finding a permanent home. The program was supervised in some respects; many adults remembered yearly visits by the agent of the Children's Aid Society. Probably the experiences of the younger children were better than those of the older children (Jackson 1986).

Whether children sent West by Brace were rescued from intolerable street life or were seized from their families, whether they had good or bad experiences, and whether there were indeed opportunities to compensate for the loss of original family are all subjects of continuing debate.

The Development of Foster Care Brace's work stimulated the development of free foster homes at a more local level. As the child welfare field struggled with how to develop foster home services, the dominant issues were (1) how to provide adequate supervision to ensure good care of children, (2) the temporary versus more permanent nature of foster homes, (3) whether

foster parents should be paid, and (4) the nature of the partnership between foster parents and professionals. As foster homes began to be used more often, debate about the relative merits of the foster home and the orphanage emerged. Each of these historical issues continues to be debated with respect to out-of-home care today.

Charles Birtwell had an early transforming idea about foster care. Massachusetts had, in the late 1860s, begun to pay for the board of children too young to be indentured (a move that roused the ire of Brace and others who thought that fostering a child was an act of charity and love and should not be done for pay). As head of the Boston Children's Aid Society between 1886 and 1911, Birtwell conceptualized foster care as a temporary measure, to be used when it was the best way to meet a particular child's need. The Boston Children's Aid Society studied foster home applicants and supervised foster home placements after they were made. Careful records were kept. Kadushin characterizes the work as "an attempt to build a science of foster family care and to professionalize practice" (Kadushin and Martin 1988:350). Eventually, these placements were made through one of a number of placing agencies. Because in Boston, as in other cities, there was an unlimited number of children whose condition could be improved, the demands on the agency and the size of the network of homes that could be developed were also unlimited (Crenson 1998). The potentially limitless nature of services to children continues to plague child welfare today.

The Debate Thomas Mulry articulated the issues in the debate between proponents of orphanages and proponents of foster care. He must have been a most interesting man. He was a Catholic, the son of an Irish immigrant, a prosperous businessman who spent much time in charity work, and, at the beginning of his work, a believer in orphanage care for children. In 1898, in an address to the National Conference of Charities and Corrections, Mulry spoke of the institution's role in the preservation of families; his arguments have a surprisingly current tenor. In the institution, he said, the "family bond" was kept intact through frequent visits, whereas children boarded out would be so scattered that visits would not be possible. The institution intended to return children to their homes, whereas families who took children usually intended to keep them until maturity (Crenson 1998:206).

Two years later in another address to the same conference, Mulry brought in a report from a committee of prominent child welfare workers. The report was a compromise between the supporters of institutions and those of foster care, a far-reaching document that laid the foundations of our current system of substitute care. It suggested that the important point was meeting the needs of individual children and that as long as those needs were met, either home or institution was appropriate. However, the report acknowledged that a family home was a more natural place for a child to grow up. The preservation of the child's own family was emphasized, and, in an idea far in advance of its time, day nurseries were suggested as a means to care for the children of single mothers and to avoid placements.

The momentum toward placement in foster care instead of institutional care carried into the White House Conference on the Care of Dependent Children in 1909. Urban areas were experiencing success with this method of caring for dependent children; that success was reported with enthusiasm. However, Crenson (1998) describes a little-noted speech in which the different condition of the African American family in the rural South was described. Richard Carroll spoke of the difficulties of placing black children in South Carolina with black families, already poverty-stricken and with as many children as they could support. Carroll ran an institution that placed children in homes out of necessity; the meager resources of the institution did not allow it to keep children there, nor did the resources allow adequate supervision of children in the foster homes. A colleague from South Carolina suggested

that the rural structure of a poor state made adequate supervision of placements for white children difficult as well. These reports apparently had no impact.

The Advantage of Foster Care In 1909, "social reform on a grand scale was once again in favor, and the orphanage was not big enough to accommodate its aspirations" (Crenson 1998:255). The saving of large numbers of children could better be accomplished through a foster care system, theoretically unlimited in size. The White House Conference on the Care of Dependent Children gave clear preference to foster home care in its recommendations. The stage was set for the widespread development of foster homes and for the eventual disappearance of large-scale institutional care of young children in the United States.

The advantages of foster care were apparent. Foster care was less expensive than the maintenance of large residential orphanages—especially as orphanage populations grew smaller because of the increasing use of foster care. And, in this era of high infant mortality, young children were more likely to survive in foster care. One institution reported a 98 percent death rate of infants in 1898; in 1904, when these infants were placed in foster care, the mortality rate was 10 percent (Crenson 1998:225). The unique needs of individual children could be better met in foster care. A family home seemed more "natural" for a child.

Many families were willing to take foster children, particularly when young children began to be placed and payment made for their care. Foster care fit well into a common American lifestyle in the first half of the twentieth century, when many families had a wage-earning father and a mother at home caring for several children. Adding a foster child was a way of adding to the family's income and providing a needed community service. As foster care became localized and professional services developed, it was possible to organize foster care so that placements would be adequately supervised.

The extended family, of course, has always been an important source of care for orphaned children and others whose parents cannot provide for them. Institutions dedicated solely to the care of children—orphanages—have usually been established either in response to disasters in which whole families have been lost or in settings, such as the frontier West, where distance has separated extended families. Foster care, too, had its beginning and early growth under conditions—those of early industrial society with its large population of poor, immigrant factory workers—where extended family was either distant or unable to assume the burden of extra children.

Foster Care Today

National data systems (described in chapter 2) present a picture of the numbers of children involved in the foster care system, their young age and long placements, and the disproportionate representation of children of color. Other descriptive studies tell us more about the characteristics of foster care. All of these have implications for the future of foster care.

Number of Children in Care

Foster care affects many children. Changes in the number reflect social policy changes, economic cycles, and community conditions. The number of children in foster care declined sharply as a result of the increased support available to families after the passage of the Social Security Act and Aid to Families with Dependent Children, then began to rise in the 1960s. In 1977, as the economic prosperity of the post-war years ebbed, it was estimated that 395,000 children were in foster care. By the early 1980s, some estimates were as high as 500,000 children (Kadushin and Martin 1988).

These alarming numbers, along with data demonstrating that once children were in foster care they tended to remain for a long time, led to nationwide efforts to move children out of foster care and into permanent homes. These efforts were quite successful. Some demonstrations, such as the Oregon Project, found that

as many as a third of the children in long-term foster care could be reunited with their families (Emlen et al. 1976). With innovative recruitment and careful placement procedures, adoptive homes could be found for older children and children with severe handicaps (Emlen et al. 1976; Unger, Dwarshuis, and Johnson 1977). By the late 1980s, it was estimated that there were fewer than 300,000 children in foster care. Child welfare professionals and policy makers expected that before long, foster care would be a small program, mainly for adolescents living in the foster homes where they had grown up and for younger children needing very short-term crisis placements.

Then, in the last fifteen years of the twentieth century, the number of children in foster care began to rise rapidly, coincidentally with the introduction of cocaine in the cities of the nation and with the increasing incidence of family breakdown. Using data from the Adoption and Foster Care Analysis and Reporting System (AFCARS) and the American Public Human Services Association, the Children's Bureau reported that on September 30, 2000, there were 567,000 children in out-of-home care in the United States (U.S. Department of Health and Human Services 2002b). Legislative and practice responses were immediate. In the following years, the numbers began to drop, as protective services focused more on preventing foster home placements, The Adoption and Safe Families Act (ASFA) mandated short foster home stays, and federal adoption incentives increased the number of adoptions from foster care, until in 2011 there were only 400,540 children in care, a major decrease in numbers. Foster home stays also became shorter; about half of the children entering foster care in 2011 had a case goal of returning to their original family, and about half were discharged from foster care within a year (U.S. Department of Health and Human Services 2012b).

Placement Settings

As figure 6.1 displays, children and young people are placed in a variety of settings. Most children in out-of-home care are in nonrelative

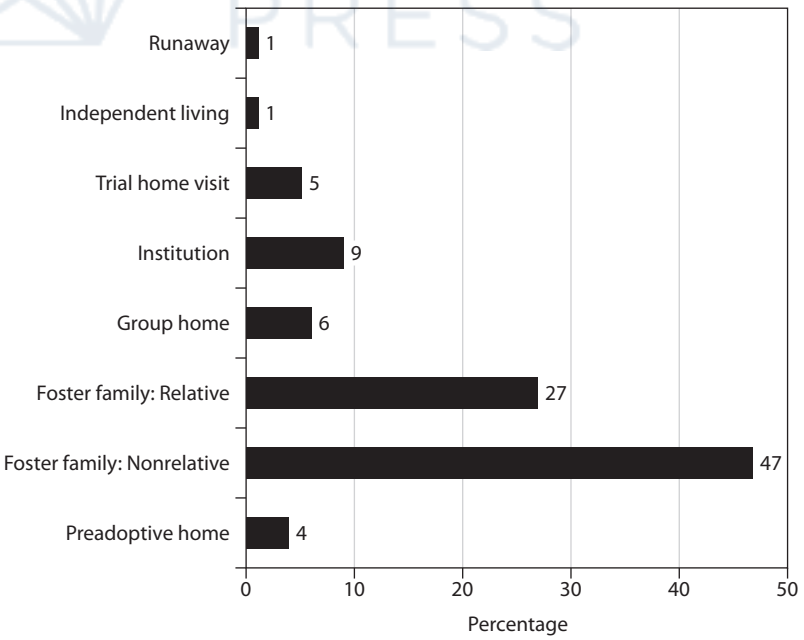

FIGURE 6.1. Placement settings of children in out-of-home care *Source:* AFCARS 2013 (U.S. Department of Health and Human Services 2013)

foster homes; this form of foster care is the focus of this chapter. Kinship or relative foster homes, described in the preceding chapter, are next in importance. Some foster homes have special training to enable them to work with very difficult children; these therapeutic foster homes will be discussed in the next chapter. Institutions and group homes are, generally, of two types: shelter or assessment facilities for children just entering care or residential treatment facilities for children and adolescents with emotional disturbance. These forms of care as well as independent living programs will be described in later chapters. Runaways, obviously, represent a failure of the child welfare system.

Despite the large number of children in foster care, it should be recognized that placement in foster care is relatively rare. Working with the data of Illinois and Michigan, researchers at the Chapin Hall Center for Children at the University of Chicago discovered that in Illinois, 7 percent of the first contacts with the child welfare system resulted in a placement, while in Michigan only 4 percent resulted in a placement.[5] Among cases in which maltreatment was substantiated, the placement rate rose to 14 percent in Illinois and 8.5 percent in Michigan (Goerge et al. 1996). National Child Abuse and Neglect Data System (NCANDS) data for 2010 show that of the children for whom a report of maltreatment was substantiated, and who received services, 64.8 percent received services in their own homes, and 36 percent were removed from their homes (U.S. Department of Health and Human Services 2012a). Some of these placements were very brief.[6]

Characteristics of Children in Foster Care

Reasons for Entry Into Care The basic reason that children enter foster care is, of course, that their families are, for a time, judged to be unable to care for them. The usual path of entry into foster care is through the protective service system, but children also come into foster care at the request of their parents, either because illness, incarceration, or similar circumstance makes them unable to care for a child or because the child's difficulties have become so severe that the family cannot provide adequate care.

Most children who enter foster care come from fragile and complex families, and it is difficult to find precise descriptive data. Neglect is the most common allegation. Family circumstances impact whether or not children enter foster care. Particularly in urban areas, very poor children and children whose families do not have a steady source of income are more likely to be placed (Barth, Wildfire, and Green 2006). Substance abuse is present in a high percentage of the families whose children are placed (Chipungu and Bent-Goodley 2004). Families are often involved in the criminal justice system. Domestic violence is present for about a third of the families whose children enter foster care according to National Survey of Child and Adolescent Well-Being data (Hazen et al. 2004).

In an analysis of ongoing cases of children 2 years old and older in the child welfare system, using data from the National Survey on Child and Adolescent Well-Being (NSCAW), Barth, Wildfire, and Green (2006) estimated that about 20 percent of the families with children in care had none of the above problems, and their children (often teenagers) had entered in order to obtain mental health services. This was a particularly important factor for families from rural areas, and probably reflects the scarcity of mental health services.

Age of Children in Care The age of children in foster care has fluctuated in the past twenty-five years. In the 1970s and 1980s, the numbers of young children in foster care dropped as permanent homes were found for many of the young children who had been discovered "drifting" in foster care. By the late 1980s, most children in foster care were 10 years of age or older (Kadushin and Martin 1988:356). Most foster care intake concerned troubled adolescents. The trend changed abruptly in the 1990s.

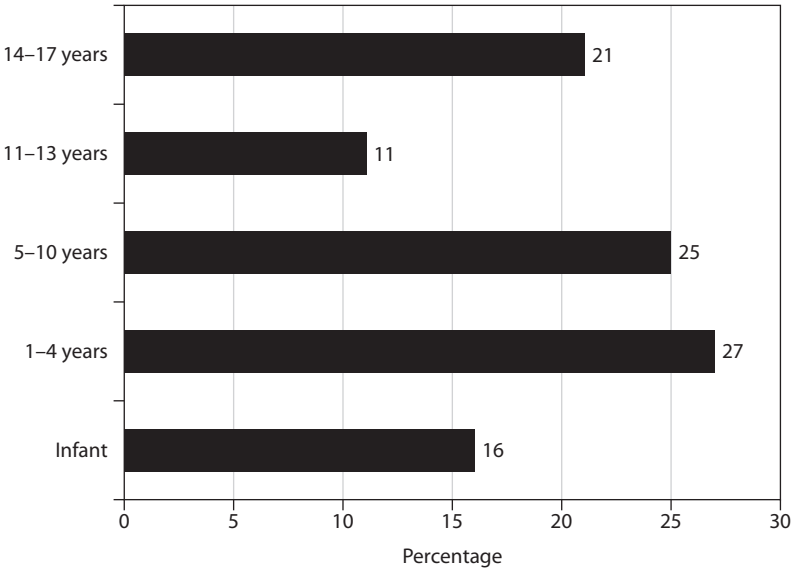

FIGURE 6.2. Age at entry into foster care *Source:* AFCARS 2012 (U.S. Department of Health and Human Services 2013)

Suddenly, it was young families with young children who were experiencing difficulties and needing foster care for their children.

By 2011, 38 percent of the children in foster care were age 5 or younger (U.S. Department of Health and Human Services 2012b). Thus, many of the children in foster care now are a young and vulnerable group, for whom prompt planning is particularly important (figure 6.2). A year in foster care is a large proportion of their lives. And, if their own families cannot be rehabilitated, their options for permanent homes grow less with each year of age, as does their capacity to make firm new attachments.

A fifth of those entering foster care are adolescent, and a third of those in foster care are adolescent (U.S. Department of Health and Human Services 2012b). While some are adolescents who have been in long foster care placements, a good proportion of these enter care because of behavioral problems that families cannot manage.

Gender For many years, slightly more than half of the children in foster care have been boys; in 2013, 52 percent were boys. The proportions are relatively close, and gender has not been an issue of concern to those writing about foster care.

Race/Ethnicity of Children in Care Racism has always troubled programs providing out-of-home care. Forty years ago, there were relatively few children of color in foster care, leading to speculation that these children were underserved by the public child welfare system. The suspicion that these children are underserved remains, for now there are many children of color in foster care, and they stay too long.

figure 3.3 in chapter 3, displayed the overrepresentation of African American children in foster care. The overrepresentation is not as great as it was a few years ago, for focused effort to work with families to prevent entry into foster care and to create permanent homes for children in foster care has resulted in positive changes. In 1996, while 15 percent of the children in the United States were African American, 51 percent of the children in foster care were African American (Child Welfare League

of America 1996); by 2011, the proportion of African American children in foster care had dropped to 27 percent. Native American children were also overrepresented in the foster care population, which might be expected with the high poverty rate, and that has not changed. Hispanic children are probably represented approximately in proportion to their presence in the population, which is interesting as this is a group of children with a high poverty rate. Asian children are underrepresented, which may mean that child welfare services are not reaching this community.

As discussed in chapter 3, the reasons for the overrepresentation of African American children are many: poverty and racism are prominent among them. Poverty is associated with neglect and abuse: African American, Native American, and Hispanic children are most likely to live in poverty. And there is evidence that racism may play a role at critical decision points in child welfare services. The National Study of Protective and Preventive Services (U.S. Department of Health and Human Services 1997) found that minority children, particularly African American children, were more likely to be in foster care—even when they had the same problems and characteristics as white children—than to be receiving services in their own homes

Children of color remain longer in foster care than do white children. This has an impact on the statistics showing their overrepresentation in the foster care system; any census of children at one point in time will overrepresent those in care for a long time. These long stays raise the suspicion that family preservation services and adoption services are not being provided for or adapted to families of color—that these families are once again underserved by the child welfare system.

Needs of Children Entering Foster Care The original purpose of foster care was to keep children safe. Gradually, that idea has evolved into the realization that if the state is to take custody of a child, the state then has the responsibility to attend to the developmental needs of the child. Evidence from many studies confirms that children entering foster care often have significant health, developmental, behavioral, and emotional problems.[7] The backgrounds that led to their removal from their homes have often included neglect of routine medical care, as well as poor hygiene and nutrition. Development is often delayed. Older children are often far behind their expected school grade; they have lived in a chaotic environment in which school attendance was not stressed and in which a transient family life due to difficulties with housing may have meant many changes in schools. Traumatic early experiences and indifferent care may have created behavioral and emotional difficulties. Overlaid is the trauma of removal from home and placement into a strange setting. It is estimated that up to 80 percent of the children who enter foster care have significant emotional/behavioral problems (Dore 2005).

An initial screening of each child entering the foster care system is an entry point to mental health services. Beyond that, there are many treatments available; emphasis is on targeting treatment to the specific disorder and on selecting treatments that are known to be effective. Payment for mental health services for children in foster care is through Medicaid; payments to providers are low, and sometimes only for a limited time. Most funding is directed toward children with problems severe enough to be disruptive in home and school. Recent concern has resulted in considerable improvement in meeting mental health needs; results from Child and Family Services Reviews indicate that 80 percent of children in foster care with mental health needs have been connected to mental health services (McCarthy and Woolverton 2005). Limited though it may be, children in foster care seem to have better access to mental health care than do children in the community with similar needs.

Children in foster care are more likely to have health problems than children in the general population. As medical care is generally organized in child welfare, taking care of children's medical and dental needs is the responsibility of the foster family. Foster parents report some difficulties in obtaining information about the health care needs of children newly placed in their homes but are generally very responsible in seeing that these needs are met. Medicaid pays for this care, and foster parents report some difficulties in finding providers (particularly dentists) who will accept the low Medicaid payments. Results from federal reviews of child welfare services indicate that most children in care received needed medical and dental care (McCarthy and Woolverton 2005).

Education and Foster Care Most studies that have tracked educational needs find that children enter foster care behind in educational achievement, and they do not catch up (McDonald et al. 1996; Walker and Smithgall 2009). At the time of leaving foster care, only half the subjects in the Northwest Alumni Study had graduated from high school (Pecora et al. 2010).

Recognizing the educational challenges these children face is important. About two thirds attended three or more different elementary schools, and one third experienced ten or more school changes (Pecora et al. 2010). Placement instability was behind many of the changes, which meant that children were frequently adapting to new homes as well as new schools. Nearly one out of ten children in a Chicago study was old for his or her grade in first grade, and more than one third by third grade (Walker and Smithgall 2009). Not surprisingly, under these circumstances a high proportion of children in foster care are found to be only marginally engaged in school. Disciplinary problems are frequent. A general response of schools to these challenges seems to be placement in special education classes, with classifications of learning disabled or emotionally disturbed. These classes, however, seem not to be bridges back into mainstream schooling; children remain in them for many years (Walker and Smithgall 2009). Given these conditions, many youth begin to attend school sporadically and then drop out.

Schools have the major role to play in intervening in this unproductive cycle to provide the support that children in foster care need, whether it is through structural changes, such as ungraded classrooms, or a change in climate to recognize the role that social support plays in learning. Child welfare workers have a role in helping schools understand the difficult times these children have been through and the special help they may need. Foster parents play the critical role, however. It is up to them to support the school in little ways such as helping with homework and in bigger ways such as attending parent teacher conferences, volunteering in the child's classroom at the school, going to PTA meetings, advocating for their children when there are difficulties—doing those things that concerned parents do and providing an educational support that these children have never had.

Characteristics of Foster Care

Length of Stay Foster homes are meant to be temporary bridges to permanent homes. Since the 1950s, professionals and the public alike have been concerned about the length of time children stayed in foster homes. In 1959, Maas and Engler published a survey regarding children in foster care in six representative states, and the child welfare world was astounded. The study revealed that large numbers of children were drifting, without any planning for their future, in long-term foster care. Care planned as temporary had become, by default, permanent. Subsequent studies repeated these findings (Gruber 1978; Knitzer, Allen, and McGowan 1978). The problem has not been solved, despite focused efforts during subsequent years to move children more quickly out of foster care. The longer children stay in foster care, the more

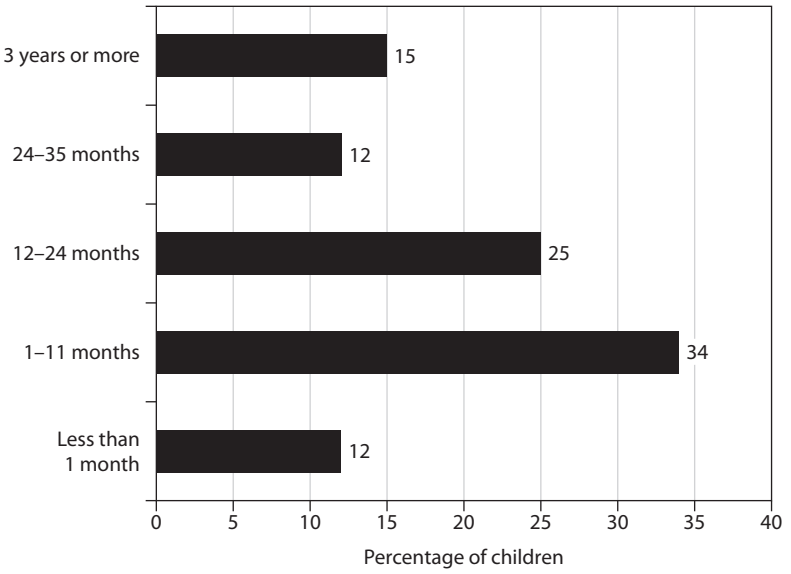

FIGURE 6.3. Length of stay in foster care *Source:* AFCARS 2012 (U.S. Department of Health and Human Services 2013)

likely they are to lose contact with birth families and to remain in care. Long stays in foster care also exacerbate the shortage of foster homes.

As is shown in figure 6.3, in 2012 more than a quarter of the children in foster care had been in care two years or more. (U.S. Department of Health and Human Services 2012b). Summarizing data on length of stay, Martin (2000) notes wide variability from one state to another and the consistent finding that African American children have longer stays in foster care than do white children.

The children who enter foster care are coming from families whose problems are serious, difficult to resolve, and often multiple. Poverty, violence, substance abuse—none of these are easy to change. Their roots lie in behavior patterns laid down through a lifetime of limited opportunity to develop more functional coping skills. If the children in foster care are to go home, and if home is to be able to nurture them, it can often take a very long time. It might seem that long stays in foster care could benefit some children and families, and indeed reentry to foster care occurs more often after a short initial stay (Kimberlin, Anthony, and Austin 2009).

Foster care, however, in the current environment of limited resources is often a less than optimal environment for children's growth and development. It is still further from ideal if children have to move from one foster home to another. The concept of the "time clock of the child" (Goldstein, Freud, and Solnit 1973) is an important one; two years is a long time in the life span of a child. Monumental developmental tasks are encompassed in two years. If children remain in a single home, critical attachments are developed. Additionally, should family reunification prove impossible, it becomes increasingly difficult to find adoptive homes for children as they grow older.

Number of Placements The longer a child is in foster care, the more likely it is that he will move repeatedly from one home to another. Each move requires that the child deal with the loss of the attachments made and develop new attachments. Slowly, children learn to believe that they will not be able to remain anywhere.

To protect themselves against the pain of loss, they become wary about forming new attachments and thus compromise their ability to develop a secure emotional base for development and learning.

Numerous studies have documented that these changes in placement have an adverse effect.[8] Multiple placements increase the risk of behavioral problems, which, of course, increase the risk of further disruptions. Most changes in placement also involve a change in schools, setting the stage for academic delays and eventually to the risk of dropping out of school. Placement changes disrupt services that are being provided. And, finally, changes decrease the likelihood that a youngster will form a bond with a caring adult and a strong support network.

It is difficult to tell whether foster care is a less stable form of care for children now than it was years ago. Statistics indicate the picture is not too different. Twenty years ago, about half of the children placed in foster care had a single foster home, another 25 percent experienced two foster homes, while "a small minority" experienced multiple placements (Kadushin and Martin 1988:414). More recently, Martin (2000) noted two distinct patterns of placement. Approximately two thirds of children in foster family care will have only one or two placements; the remaining third will move multiple times. Pecora (2009:210) noted the wide variability among studies and agencies in reports of placement changes, but it is clear that the longer children are in foster care, the more likely they are to experience multiple moves.

Foster home placements disrupt for a variety of reasons, usually an accumulation of stressors over time until in the end an incident becomes the "final straw." Children's behavior problems are often the reason that foster parents request replacement (Oosterman et al. 2007). There are other reasons—changes in family composition, health problems or other crisis in the foster family, and agency decisions to replace a child. Children who are older at first placement are likely to have a subsequent placement (Oosterman et al. 2007). Placements with relatives tend to be more stable, as we saw in the past chapter.

Could these multiple moves have been prevented? As efforts have increased to provide supportive services to families and to keep children in their own homes, it is possible that children are being left longer in difficult situations so that when they do come into foster care, their problems have deepened and their behavior is harder to manage. Scarce resources may also mean that agency workers do not respond promptly to a foster parent request for guidance. Meanwhile, the shortage of foster homes limits the child welfare agency's ability to match the specific behavioral difficulties of a child with the competencies of a foster home. If a foster parent has difficulties with a particular child and requests his or her removal, the agency may be tempted to preserve the home for future children by acting quickly to comply. All of these factors increase the number of moves that children experience.

The Foster Care Experience

When foster care is considered for a child, there are three parties whose interests are represented and who must be considered as the experience unfolds. First, of course, is the child. The children are the most directly affected by foster care; care needs to be shaped to meet specific needs, and reactions and opinions should be assessed and attended to. Biological parents are critical (fathers as well as mothers) both for the role they can play while a child is in foster care and because of the work they must do if the child is to return home. The foster family is the third party, assuming the daily care of the child, but also taking into their home the child's representation of the original family as it is expressed verbally and in behavior. The social worker should be the glue that binds these three parties together in their common endeavor to make life better for the placed child.

It might be supposed that a child would be relieved to be away from biological parents who have been so abusive or neglectful that the child has been removed from their care. However, children long for their absent parents and long to return home. Testimonies of foster children, such as those presented later in this chapter, document this longing.

Parents also mourn for their separated children. They resist the label of bad parents and consequently may resist the efforts of the child welfare agency to shape them into better parents.[9] The actions of biological parents in using agency resources to ameliorate difficulties and in continuing to visit the child are critical to the child's well-being in foster care and to the return home. However, it is easier for biological parents to blame an authoritarian agency rather than themselves or, in the case of an older child, to blame the child. Skilled work by the caseworker may be necessary to enable the parents to accept offered help.

One would expect that if family problems were identified as reasons for placement of a child in foster care, the system would make every effort to address these problems prior to the child's return from foster care. Unmet service needs are associated with further maltreatment and return to foster care (Festinger and Botsko 1994). However, there is evidence that services are not necessarily tailored to the problems that the parents perceive (Sykes 2011; Estefan et al. 2012). This is clearly a serious problem if the child is to return to the original home, as most children do.

The foster family also has needs that must be met. If families are to remain good and stable foster homes, the experience must be rewarding to the family. If foster care is to be a healing experience for the child, families need information and help in providing day-by-day care. If foster parents are to be role models and assist biological parents, as they are increasingly being asked to do, they need help in understanding these parents, often from very different backgrounds. The child welfare agency is largely responsible for seeing that these conditions are met.

Collaborative work among these parties is obviously necessary and is difficult. In the case from our study of protective services, the voices of the mother, the foster mother, and the child welfare worker appear in the following sections, illustrating the differing perspectives of the participants (box 6.1).

BOX 6.1

Ms. W. is a single parent with two boys, aged 6 and 10, in the hospital following the birth of a third child. At birth, her daughter tested positive for drugs in her system. Ms. W. had had prior contacts with child protective services; complaints had been that the boys were neglected. Substance abuse had been identified as a problem in past contacts. The neglect was not considered serious enough for protective services to take authoritative action. The children had not been placed, and other than encouraging the mother to go to substance abuse treatment, no services had been offered to the family.

The mother: *"I really didn't think they were going to take her, especially like they did. The worker walked in there and jerked her up off that bed and she wouldn't let me hold her, she wouldn't let her brother say good be to her. Nothing. She walked out with her. Ten minutes and she was gone.*

"I hate her, and I don't work well with her either. I didn't want to be honest with her; I didn't want to tell her nothing. I didn't feel like I could trust her. Everything I said and everything I did was used against me. I felt, with her . . . as a matter of fact, I knew, that as long as she was on the case, I would never get my kids back."

The worker: *"We got a call from the hospital that mom had given birth to a drug-affected baby. She disclosed to hospital staff that she had prior contacts with the child welfare agency, and that she did not know who the father of the child was. . . . The decision was made to detain the child. . . . I had to do so much research into this one, because the information from the other state was so lengthy. . . . So at the very beginning, my concern was the safety of the baby.*

And I figured between extensive visitation and a lot of contacts with the mom and anybody she wanted to bring into the office. . . . Mom is a fighter. I consider that a strength. Sometimes it is frustrating, but it is a strength."

The Child's Original Family

Biological parents are frequently the least assisted of all the participants in the foster care of a child. They are often the victims of negative labeling and authoritarian treatment by social service agencies. Workers confuse compliance with engagement in services.

Characteristics of Biological Parents The needs of these parents are often extensive. Parents involved with the child welfare system are disproportionately likely to need mental health services. More than half meet diagnostic criteria for major mood disorders, such as depression (Marcenko, Lyons, and Courtney 2011). Estimates vary, but there is general agreement that about 60 percent of the parents of children in out-of-home care are involved with alcohol and/or drug abuse; their children are less likely to return home and more likely to be readmitted to foster care after a return (Brook and McDonald 2009). Estimates of the prevalence of family violence range from about a third of the families to 14 percent (Kohl et al. 2005). And, almost always, poverty is present—often extreme poverty (Barth, Wildfire, and Green 2006; Marcenko, Lyons, and Courtney 2011). Further inquiry into the status of these families reveals that high proportions experience multiple risk factors.

Crafting Services Child welfare workers, on the whole, have not proved adept at identifying individual needs of families and fitting services to those needs. Festinger and Botsko (1994), in a study of children returning to care, note the large number of caseworker recommendations for counseling or therapy, coupled with notes describing families with multiple problems—such as poverty, poor housing, isolation, substance abuse. In the almost twenty years since this study, it might be hoped that services were being better tailored to needs, but inquiry into parents' perceptions reveals that still about a third see themselves as needing but not receiving help with clothing, housing, finances, and/or food (Marcenko, Lyons, and Courtney 2011). Sykes (2011) has written of mothers' need to preserve self-image as a good parent and subsequent refusal to believe that any services concerning parenting are needed—and it is help around parenting that a child welfare agency is most likely to offer. Examination of the interaction of workers and families reveals that it is difficult for caseworkers to identify the specific needs of children and families and to match services to those needs (Shireman et al. 2001).

As discussed in chapter 3, often the caseworker focuses on the mother in assessing needs and planning services. Sometimes only the mother is available initially, as in the case illustration in this chapter, or the mother is the custodial parent. But fathers, even absent fathers, remain a force in the lives of these families, and the importance of fathers has been amply demonstrated. Several factors within agency protocols assist the worker in ignoring the father; in most jurisdictions, cases are filed under the mother's name, mothers are perceived as the principal caretaker (and given the responsibility of protecting the children), a case is simplified and workload lessened if only one parent is active, and until late stages of a case when adoption is being considered, it is not legally necessary to involve the father. Additionally, as part of a complex relationship, mothers may be reluctant to involve a father. One study found that only 54 percent of the children in foster care had contact with their fathers in the past year (Coakley 2013). With the father's capacities unknown, a potentially valuable resource in planning is ignored, and children are deprived of a source of support.

A gap between family needs and agency services exists. The services that an agency can offer are dependent on its resources and vary greatly. Some needs, such as poverty and substandard (or no) housing, may be beyond the capacity of the child welfare worker to meet. The child welfare worker can, however, link the family with social agencies that can help and advocate for the family with those agencies. In the same way, the worker can be active in collaboration with agencies that provide treatment of substance abuse, support for victims of family violence, mental health services, or any of the other services that may be needed. Shortages of services in the community, and workers' frustration at inability to meet needs associated with poverty, need to be recognized.

Another part of the reason for the gap lies in the allocation of the scarce resource of child welfare workers' time: child welfare workers must spend so much time investigating maltreatment allegations that they do not have sufficient time available to work with families once the need is established. The gap also reflects inadequacies in the training of workers. But a major part of the problem is simply worker inattention to the unique needs of particular families, worker failure to engage with the families in joint service planning, and a lack of creativity, time, and energy for the task of developing services to meet those needs.

Part of the reason for this gap between needs and services lies in the authoritarian stance all too often taken by the child welfare agency, defining maltreatment according to legal definitions, making decisions to remove a child from the family, and leaving the parent helpless, frustrated, and angry, and with a long list of mandated services. Child welfare agencies usually assess the difficulties of families, and the court mandates services, such as substance abuse treatment or parenting classes, to remedy these difficulties, and parent participation becomes a condition of the return of the child. Parents are asked to "comply" with these demands. At some level many do, because they want their children returned, but only if a service really meets a perceived need do they fully engage in using the service (Estefan et al. 2012).

Child welfare agencies have not always kept parents well informed regarding the status of their children, nor have parents always been allowed to be active participants in the decisions affecting the family. These problems have given rise to the adversarial juvenile or family court proceedings that are designed to protect the rights of parents. System restructuring toward a more family-centered framework is taking place in many states and may help caseworkers and families engage together in actions that will benefit children.

Family meetings have proved useful in involving parents in joint decision making when the children are in foster care, as our example of box 6.2 illustrates.

BOX 6.2

The mother: *"That was good. We had two unity meetings; they were really good. As a matter of fact, my drug and alcohol counselor said that the first one was one of the best ones she's ever been to. . . . The second one, the caseworker was there. Myself was there. The facilitator was there. Nancy, my parenting teacher, was there, my drug and alcohol counseling was there, my mental health counselor was there. My bible study teacher was there. My aunt was there, my cousin was there. The paternal grandmother was there again. My oldest son's legal father, his girlfriend was there, and then his dad's brother's wife was there. So there were quite a few people there. I wanted my grandma there, but she had to work. . . . I basically said anything I wanted. . . . The second meeting was wonderful. I feel it is going to go a lot better now."*

Working Together Parents are able to provide essential information about the lives of their children. They can and should be active participants in introducing their child to foster care, in the treatment planning, and especially in permanency planning. Even if parental rights

are going to be terminated, it is helpful to everyone if parents have a place at the table where decisions that affect their children are made.

Families whose children are in placement are not easy families to engage in remedial work. Their anger and defensiveness present obstacles. Once a child is out of the home, for both worker and family the crisis is resolved. The child's need of parents is great, however, and the family's investment in the child is great. It is through their common recognition that the needs of the child must be met that the worker and parent can come together and engage in a service plan that will truly meet family needs (see box 6.3).

BOX 6.3

The mother: *"It is not that I have a problem working with the agency, because I don't have a problem at all working with my new worker. She does tell me that I am doing good, keep up the good work, and stuff like that."*

The Foster Care Experience for Children

Though foster care has more impact on children than on anyone else, the voices of these children are just beginning to appear in the literature, both in reports from children in foster care and in the recounting of their experiences by youth who have been in foster care. These reports confirm our adult concerns about the impact of separation and the importance of maintaining attachment, and about the difficulty of re-placements. They illustrate that some foster homes are better than others. At the same time, they provide evidence that the safety and predictability of a good foster home are welcomed.

The Children Children entering foster care have been exposed to poverty, parental absorption in substance abuse, family violence, and mental health issues. Most have been abused or neglected. As a result, they may have poor physical health, compromised brain functioning, inadequate social skills, attachment disorders, and mental health difficulties (Harden 2004). They have also been separated from their main source of support—their families.

Data from the Urban Institute's National Survey of America's Families indicate that more than a quarter of the children in foster care have a physical, learning, or mental health condition that limits their activities. Twenty-seven percent have high levels of behavioral and emotional problems; a third were suspended or expelled from school in the year prior to the data collection. Thirty-nine percent have low levels of engagement in school (Kortenkamp and Macomber 2002). These are going to be difficult children in a foster home and are going to need skilled and committed parenting. And foster parents are going to need help and guidance from the child welfare worker.

Meeting Developmental Challenges The behavior of children entering foster care varies with the age of the child, the experiences the child has had, and the resilience of the child. The consequences of maltreatment play out while the child is in foster care. Problems are likely to increase or remain stable with placement into foster care (Fanshel and Shinn 1978; Vanderfaeillie et al. 2013). Thus, a continuing strain is placed on foster parents, who report that the most difficult experience of fostering is having children who are unresponsive to usual discipline (Buehler, Cox, and Cuddeback 2003). The child's perspective is hard to find in this dynamic, and the consequence of a disrupted placement can be devastating.

Harden (2004) writes of the responsibility of the child welfare system to ensure both the continuity of care that children need to overcome early adversity and the need for continual attention to children's developmental progress and the provision of appropriate services. Foster children are major consumers of mental health services; school support is almost universally needed. Children of color may need additional

support in development of racial/ethnic identity, particularly if they are placed in a foster home of a different racial or ethnic background. Coordination of this care is the responsibility of the child welfare worker.

Children tell us of another factor affecting their behavior. Children are often ignored when planning is done, and they are sometimes ignored when they are in placement. Child welfare workers are required to visit foster homes and supervise the placement—the frequency of such mandated visits varies greatly. The worker is the child's advocate if there are difficulties. However, foster children must have opportunity to share any problems and sufficient trust in the worker to share them. And workers, pressed by the shortage of foster homes and eager to preserve the placement for a child, are not always receptive to children's expression of difficulty. Children have, of course, discovered a way to compel adult attention—difficult behavior, preferably acting out behavior. It is a mechanism that probably worked for them in their former homes, and they will try it in foster care. Toth reports children talk of deliberately being "bad" in order to get attention and get moved to what they hope will be a more favorable placement (Toth 1997). The worker must, thus, listen not only to parents and foster parents but also to the children.

What the Children Say For many years, the best evidence about children came from theoretical writing and descriptions of best practice based on clinical work with children. In 1960, Eugene Weinstein published a careful study based on interviews with 61 children between the ages of 5 and 14 in foster care. He found that visits from the child's natural parents were associated with well-being. Children who identified with their natural parents had the highest well-being ratings; children who were visited by natural parents and identified with foster parents also did well. Finally, an adequate conception of the meaning of foster care status and the reason for being in foster care were associated with well-being (Weinstein 1960:17–18). Though the study was never replicated, the findings made sense and shaped practice.

The point of view of the children who had been in foster care began to be heard as studies of outcomes of foster care appeared. Both Festinger (1983) and Fanshel, Finch, and Grundy (1990) published follow-up studies based on interviews with young adults who were foster care alumni. The publications from these studies contain many direct quotes from those interviewed.

In the late 1990s, additional information based on systematic interviews with children began to appear (Johnson, Yoken, and Voss 1995; McAuley 1996; Toth 1997; Folman 1998; Wilson and Conroy 1999). All of these investigators inquired into the meaning of placement to a child, and many followed the children through their foster care experiences. Outcome studies add the voice of youth remembering their foster care experiences (Fanshel, Finch, and Grundy 1990; Pecora et al. 2010). Finally, data from the NSCAW interviews with children in foster care added another voice (U.S. Department of Health and Human Services 2007). The themes that emerge are remarkably consistent.

Somewhat unexpectedly, in light of the current concerns about foster care, this research is indicating that children in family foster care tend to evaluate their experiences positively, most liking their foster family, feeling "loved" and "safe" and believing that their quality of life was improved by moving to out-of-home care (Wilson and Conroy 1999; U.S. Department of Health and Human Services 2007). Surprisingly, half of the children over 11 in the NSCAW study wanted their current foster home to be their permanent home, and a third wanted to be adopted (U.S. Department of Health and Human Services 2007). Johnson reports that 60 percent of the children in her study thought it sometimes appropriate for a child to be in foster care, citing improvements in care and safety (Johnson, Yoken, and Voss 1995). Evaluations were mixed when older adolescents or young

adults were asked to assess their experience, with both positive and negative experiences recounted (Fanshel, Finch, and Grundy 1990; Pecora et al. 2010).

Children report feeling tremendous anxiety and fear of abandonment when they are placed, experiencing the "trauma of separation and placement" (Littner 1950). Usually little is done to help them understand placement, to prepare them for placement, or to reassure them that they will see their parents again. "[They should] at least not take us away without our parents knowing. It seemed like we were going to jail," reported one child, who had apparently been placed from school (Johnson, Yoken, and Voss 1995:970). Siblings become very important, both as supports during the frightening times of placement process and later as the people who help children maintain a sense of family.

Children have and maintain a wish to be reunited with their families, and most continue to identify themselves as members of their original families. Children age 6 and over in the NSCAW study wanted more contact with biological parents, and 60 percent believe they will live with them again, and more than two thirds express a preference for living with mother or father.[10] Visits are important, but 61 percent report that they see their mothers, and 70 percent their fathers, twice a month or less (U.S. Department of Health and Human Services 2007). And as adults, many former foster children maintain monthly contact with siblings (59 percent), birth mothers (41 percent), and/or birth fathers (21 percent; Pecora et al. 2010).

The boys in the case we are following were placed in foster care immediately after their newborn sister was placed, as it was thought that the mother's use of drugs created a dangerous home environment for them. The worker in our example did not prepare the boys for a move prior to their placement in foster care, but did allow them time to express their feelings (see box 6.4).

BOX 6.4

The worker: *"Then I came back and talked to the boys, and the response of the boys was, 'Well, we told her if she didn't stop using we were going to be taken.' So we sat there and I let them cry on my shoulder, and we talked. Then the foster parent came and picked them up. . . . So we spent probably four hours with the boys that day, that afternoon, just trying to make things as calm as we could for them."*

Overall then, the picture is one of placement itself as a terrible, traumatic time for children, especially if it is from home to foster care, but also if it is from one foster home to another. Once in placement, children experience greater feelings of safety and often recognize that their quality of life has improved, though they remain identified with their original families, and most long to return.

The many ways that workers could make placements easier for children—explaining what is happening, giving children some voice in plans, working to support families and keep placements stable—are evident. As, of course, is the importance of the worker's efforts to facilitate family contact and to rehabilitate the original home for the children's return.

One suggestion that emerged from work with youth from foster care was that of groups where foster children could get to know each other, realize that there were others in the same situation, and draw support from each other. Many child welfare systems with youth in foster care have instituted such groups. With the expansion of the Internet, these foster children have gone online: the website www.fosterclub.org/ is colorful and full of stories, conversations, opportunities for advocacy, and a sense of community.

Maintaining Continuity with Family

Children entering foster care are dealing with multiple difficult experiences and are coping without the support of parents—parents who, however inadequate, have been the child's source of information and encouragement as

new experiences occurred. Both parents and children have experienced loss with the placement. It is important to the family's well-being and the child's development that continuity be preserved to the extent possible.

Visiting Visits with parents are very important for children in foster care. Visits were not always encouraged: Fanshel (1982) found that of 23,051 children in placement in New York City for more than ninety days, only 13 percent saw their parents at least once a month, and half were not visited at all. Then early research documented the importance of parental visits, and the findings have not been challenged. In a classic study of the long-term fate of 624 foster care children in New York City, visiting was found to be the best predictor of return home (Fanshel and Shinn 1978). Research has also demonstrated a relationship between visiting and a child's sense of well-being and overall adjustment (Weinstein 1960; Fanshel and Shinn 1978; McWey and Mullis 2004). The benefits of parents visiting their children in foster care have become "practice wisdom": current recommendations are that the first visit occur within twenty-four hours of a placement and that visits be twice a week or more often for very young children. There is continuing work in training workers in ways to make visits therapeutic for parents and children.

The feelings of biological parents, particularly those of loss, anger, guilt, and shame (Jenkins 1981; Sykes 2011), may act as disincentives to visiting the children in foster care. Foster parents are not always gracious to parents whom they perceive as having maltreated their children, and they may experience the visits as disruptions. Children, too, are often upset by visits. Financial circumstances can make visits difficult. Foster homes are often far from original homes, and transportation can be difficult, costly, and time consuming.

Parental investment in visits is seen by child welfare workers as a marker of their interest in their children and is one of the factors considered when reunification decisions are made (Wulczyn 2004). Visits provide an opportunity for workers to observe parents and children together and with therapeutic guidance can become instruments for change.

A place for visits is often an issue. The foster home provides a natural setting for the child, and, if foster parent and biological parent are comfortable with each other, can create easy visits. Offices are often used and do provide a neutral place where families can be together, but they are not well liked. When parents and children can visit together in the community, there is opportunity for many more activities and varied types of interaction.

It is up to the social worker to stimulate interest in visiting, to help parents work through the practical difficulties, to provide a comfortable place for visits, and to help parents deal with the emotions that make visits difficult. Furthermore, planned visits with specific goals can help both parents and children work through their feelings, thus becoming one of the therapeutic tools that move the family toward resolution of its problems.

The mother in the case being followed in this chapter sums up in box 6.5 the problems and rewards of visits from her perspective.

BOX 6.5

The mother: *"I have made every one of them (planned visits) on time. I haven't missed one. The three that I have missed is because of the agency's problem with their timing and stuff. . . . It is fun to visit them. But when the boys were with me and we were going to see the baby at the office, we only got to see her two hours a week. But by the time the hour was up the boys were so bored, because there is not really, and knowing that somebody was on the other side of that window watching us, it is not a very comfortable feeling. But now that we get to move to [a new visiting center] it is a lot better. And the worker lets us take them out to breakfast, as long as we pay. So it is a lot better. There are games there. It is clean, vacuumed. It is more of a living room type of setting."*

Siblings Helping a child maintain his relationships with siblings can be crucial to a

child's well-being in foster care, and these sibling relationships formed during childhood may be the adult foster child's closest connection to family. Siblings are important: *sibling*—originally meaning "little kinfolk"—is among the oldest words in the English language, illustrating the importance of the relationship (Hegar 2005). Currently, common usage defines siblings as having at least one parent in common, but in this era of blended families, attention also needs to be paid to children who live together and form sibling bonds, though biologically unrelated. As case records are often kept in the mother's name, in child welfare siblings tend to be defined as children with a common mother, but a paternal bond can be equally important. It is estimated that approximately three quarters of the children who enter foster care have siblings who also enter foster care (Hegar 2005).

It is clear, both from common sense and from what children tell us, that the presence of siblings takes some of the fear and loneliness out of separations and moves. The 2008 Fostering Connections to Success and Increasing Adoptions Act was the first piece of federal legislation concerning sibling placements, and it mandates that reasonable efforts be made to keep siblings together. It is expected that the monitoring of practice through federal Child and Family Services Reviews will assist in implementing this policy.

Keeping siblings together can be a challenge for the child welfare worker. Smaller sibling groups, in which all the children enter foster care at the same time, are most likely to remain intact (Shlonsky et al. 2005; Wulczyn and Zimmerman 2005). Kinship foster homes are more likely to be willing to absorb large sibling groups (Washington 2007). If children enter foster care at different times, and the foster home with siblings already in care cannot take in more children, a difficult decision has to be made, weighing sibling contact against a disruption in continuity of care. Sometimes one child in a sibling group has special needs and is placed where those needs can best be met—there is little or no information on the outcome of this pattern.

Agency culture is also important. How professionals view sibling relationships in general, the priority joint sibling placement is given in practice, and how practitioners perceive conflict between siblings can all serve to undermine policy. Staff and Fein (1992) examined sibling placement for Casey Family Services, a private social service agency, at five different sites over a span of fourteen years. The results of this inquiry provide a dramatic demonstration of the impact of worker attitudes and workplace cultures. In the five sites, though policy was the same, placements where siblings remained together ranged from zero at one site to 69 percent at another. Though the data are old, the importance of branch culture is vividly illustrated.

There is limited literature on the outcomes of sibling placements. Hegar (2005) found that placements of intact sibling groups tended to be more stable, though she questioned whether this was a causal relationship. Webster et al. (2005) found that children placed as sibling groups were more likely to reunify with parents. There is consensus that keeping siblings together is beneficial, though there is also consensus that there needs to be evaluation of the relationships and needs of each sibling group as placement decisions are made. The first placement decision is critical and may set a pattern for many years of care.

Contact with Extended Family A foster care placement with relatives (kinship foster care) can ease many of children's difficulties of separation from family. Additionally, when compared with children in nonrelative foster care, children living with relatives were more likely to feel "always" safe and "always" loved (Wilson and Conroy 1999:61).

When children are asked to describe the foster care experience, relatives emerge as important. Even when children are not living with relatives, they may visit them, spend holidays with them, or be visited by them. These

contacts reinforce the children's identity as members of their own families. They also provide opportunity to see siblings and to maintain relationships with extended family.

In the situation we are following, the strong relationship of the boys to each other and to their mother is important in case planning. One wonders if the planning might have been different if the siblings had been placed together or if the placement had been with a relative (see box 6.6).

BOX 6.6

The worker: *"I would say [that I am] pretty hopeful, because there is such a strong relationship [with the boys] there. This would be a case that even if the twelve months were up, it would need to be given consideration for extended time. With the baby, I don't know. It would depend strictly on what mom decides to do."*

The Foster Parents

The experiences of being a foster parent are intertwined with their interactions with the social worker, the biological parents, and the children themselves. These dimensions are explored in the following paragraphs. In the final section of this chapter, as recruitment and training are examined and the supports that foster parents need if they are to continue to foster are outlined, the focus is on the foster family itself.

Characteristics of Foster Parents Who are foster parents? The short answer is that they are a group of people just about like everyone else, and there is relatively little descriptive data about them. Cautley (1980) in a study of 115 new foster parents created a careful description, and other studies have produced similar descriptions (Fanshel and Shinn 1978; Berrick, Barth, and Needell 1994; Seaberg and Harrigan 1999). NSCAW provides descriptions of the foster parents with whom children in its sample had been in care for a year—including children reunited with their families in a subsequent year—and from this sample a more current description can be drawn.

The NSCAW data note some changes that impact our stereotypes of foster parents. In 1980, most foster parents were married couples; in 2005, only 70 percent of the foster parents were married. Educational level is similar to the past, with about a third having education beyond high school. Earlier studies found three quarters of the foster fathers employed; NSCAW data report that 41 percent of the caregivers work full-time; gender is not specified; 36 percent are not employed[11] (U.S. Department of Health and Human Services 2007). Many foster parent incomes are close to the poverty line, suggesting that additional income from fostering may be very important to these families (Smithgall, DeCoursey, and Goerge 2008).

Forty-two percent of the foster families surveyed in NSCAW are white, 40 percent black, but Hispanic foster homes (11 percent) are underrepresented. While less than half of the Hispanic children in the study are living with a same-race caregiver, on a positive note more than three quarters of the other children are with a same-race caregiver (U.S. Department of Health and Human Services 2001).

Commonly expressed motivations for fostering include the enjoyment of children and the desire to be of use in the community (Seaberg and Harrigan 1999). Foster parents often expect that a foster child will bring some specific benefit to the family, such as a companion for a child currently in the family or additional income (Cautley 1980). The households are larger than those of most, with a high proportion containing five or more children (Orme and Buehler 2001; U.S. Department of Health and Human Services 2001).

Foster parents have a range of years of fostering: kinship foster parents tend to have the fewest years, having taken in a specific relative who needed a home. The non-kin foster parents

in the NSCAW sample were often experienced foster parents; more than one third had six or more years of experience (U.S. Department of Health and Human Services 2001).

The foster mother in the example of box 6.7 is the foster mother of the baby in the case we are following. In experience and in many other respects, she is similar to caregivers in the NSCAW sample.

BOX 6.7

The foster mother is a middle-school teacher and has had twelve foster children before taking this baby.

The foster mother: *"Like we've said, the kids are great. The whole reason behind this, and we went to [foster parent training] classes before we were married, because I had a child [in my class] at school, a special needs child, go into foster care, and I wanted to bring him home. I felt so bad for him, I wanted to bring him home. So when [my husband] and I were dating, I said 'How would you feel about being a foster parent?' And he said, 'Tell me about it.' "*

The Role of the Social Worker The role of the social worker with the foster parents has a dual aspect, as is often the case in child welfare. Once a child is placed in a foster home, the social worker has the responsibility to monitor the placement and ensure that the child's needs are being met. At the same time, the social worker and the foster parents are partners in meeting those needs. The social worker is responsible for providing ongoing support and help to the foster parents as they care for the child and for using their knowledge and including them in the planning for the child.

In working with foster parents, often most of the contact is between the foster mother and the caseworker, as it is presumed that the mother is the chief caretaker. There is very little information from the perspective of foster fathers; it is quite recent and does not substantially alter the picture of fostering that foster mothers have provided. It tends to show foster fathers as being interested and committed to fostering, sharing in caretaking with foster mothers, and viewing the provision of a corrective family experience as important (Wilson, Fyson, and Newstone 2007; Riggs, Delfabbro, and Augoustinos 2010).

Caring for a foster child can be challenging—most are children who have been neglected or abused, whose developmental needs have not been met, and who have had little support in overcoming the effects of this trauma. Others are in care because of severe emotional and behavioral problems. All children experience the stress of placement and the need to make their way in a new home. Most children, after a time of seeming to adapt, will test the affection of the foster parents with a variety of problematic behaviors. Many children will, to some extent, attempt to re-create their own family systems, shaping foster parents by their behavior and provoking reactions similar to those of their own parents. Children are afraid of new attachments to foster parents, fearing they will be followed by rejection. Attachment to the foster parents also implies disloyalty to own parents—a dilemma for the child. The child thus creates a complicated life within the foster family, and an important part of the social worker's role is to support the foster parent in understanding and coping with these issues in order to maintain the placement for the child.

To build a working relationship, it is vital that the worker and foster parent have continuing contact. Too often, the stress of heavy workloads causes workers to neglect this contact. Foster fathers are often ignored because the worker assumes that the mother is the caretaker. Most child welfare agencies have regulations that specify how often a foster home must be visited and a child seen; even these mandatory visits are sometimes slighted by busy workers responding to other crises. This leaves foster parents without support.

Even more difficult for a foster parent is to be ignored by the child welfare worker when in need of help. Foster mothers report that they are unable to contact workers by telephone when

they need advice, clothing, referrals for medical care, or other kinds of support. In a foster parent survey in Oregon, only half of the responding foster parents said that a worker would usually return their telephone calls the same day or the next day (Shireman 2009). One can imagine the frustration of a foster parent and the feeling of being left alone with a difficult situation.

The foster mother we are following in this chapter expressed her frustration around an experience with a worker for a child no longer in her home (see box 6.8).

BOX 6.8

The foster mother: *"I called the caseworker in one week's time, sixty-five times. Never got a return call, never got a message answered. Finally she did answer the phone; she wanted to know what the noise was when I explained to her what was going on with him about his screaming for days at a time. . . . He [an older foster child] was way out of control. He did a thousand dollars worth of damage to our home."*

In the best of circumstances, the responsibility of the social worker to monitor the progress of the child is carried out in partnership with the foster parent. Foster parents grow wonderfully attached to children and are often persistent advocates with agencies, schools, and medical institutions to see that children get what they need. Workers need to support this advocacy.

At the same time, as we have seen, occasionally children are neglected by overburdened foster parents or abused. A great many of these tragic situations could be prevented by frequent interaction between foster parent and worker, which would allow the worker to become aware of stress as it developed in the foster home and to take corrective action. A delicate balance has to be maintained. The worker must make the foster parent a partner in caring for and planning for the child, while avoiding overidentification with the foster parent that might cause difficulties to be overlooked.

Foster Parents and Biological Parents Increasingly, foster parents are being asked to have contact with the child's biological parents and to serve as role models or even mentors. This is not always easy for foster parents. The relationship between foster parents and biological parents has often been strained, with the foster family focused on the child and often angry at the biological parent for maltreatment of the child. Visits are often scheduled outside of the foster home, staff transport the children, and foster parent identities are sometimes not shared with biological parents.

These patterns are very slowly changing. Research has consistently shown that visits by the biological family are critical for the comfort of the child and are necessary if the child is to return home. Current recommendations are that the first visit occur within twenty-four hours of a placement and that visits be twice a week or more often for very young children. It is thus almost inevitable, if these recommendations are followed, that the foster parents and biological parents will become acquainted. With the child as their common concern, these interactions can be positive. And foster parents are demonstrating their capacity to facilitate visits; the effort that they will make to see that siblings remain in contact is really quite remarkable—as the foster mother's report from the case we are following illustrates (box 6.9).

BOX 6.9

The foster mother: *"We used to drop the baby off for visits and pick her up. We gave her [the mother] a high chair and a stroller; we would bring her formula. Because we didn't know how much assistance or help she was getting. And we wanted to make sure at least that the baby had formula while she was there.*

"Right now the oldest boy's foster mother—he calls her his stepmom—and myself are doing the visits [of the siblings] between us. There is no caseworker in between that. And we are now trying to incorporate the younger brother, because he has been put in another foster home. He has been invited Saturday

to the baby's birthday party. . . . [We worked this out because] the oldest boy was calling. He would say 'When can I see my little sister?' and that was fine with us. We were perfectly comfortable with both families being together and playing together and stuff."

Foster Parents and Children We expect a great deal of foster parents. We expect them to give constant care over long time periods and to be willing and helpful in facilitating the move of a child to whom they have become attached. We know that successfully nursing a child through an illness or seeing success in helping a child with developmental or behavioral problems promotes a strong bond (Meezan and Shireman 1985). We expect foster parents to be interested in adoption if the child cannot go home, but not to be so attached to the child that they cannot let it go if another plan is made. Too often, we are too busy with current crises to help foster parents with their feelings of loss after children leave. And yet we expect them to continue to foster.

In box 6.10, the foster mother is expressing her frustration with the planning going on for the baby in the family; note that she is hinting that she would like to be involved in the planning.

BOX 6.10

The foster mother: *"So I packed up her baby book, her shot records. . . . I wrote down her sleeping habits and everything for them. And we went to court, and the judge said 'That child is not going anywhere. She will not be leaving that foster home.' . . . We would like to keep her until they decide what they are going to do with her.*

"We have had twelve kids, and out of every set there is one kid that I would have loved to have kept. Just because I like the underdog. We had a little kid who couldn't crawl, he was so anemic, he was a sad little guy. I would have kept him in a heartbeat. Just because he busted my heart, you know. We had a little girl that couldn't talk, two years old and didn't talk, and she was here two weeks and she was talking. So every set. It is not that I want a house full, it is just, you know . . . "

Outcomes of Foster Care

The three outcomes specified for all child welfare services apply also to foster care. Safety is measured by reports of maltreatment and by readmissions to foster care due to abuse or neglect after a return home. Permanency outcomes emphasize the definition of foster care as a temporary, crisis-oriented service and measure the percentage of children who move to permanent homes and the span of time until the child is in a permanent home. The third measure is that of the well-being of children in foster care. Well-being is measured by placement stability and the percentage of young children placed in group homes, as well as through inference from the data on maltreatment and permanency. There is great variability among the states in outcomes and in the settings in which foster care services are delivered. Differences are significant enough to cause some critics to question setting national outcome goals (Schuerman and Needell 2009). However, most states are making some progress toward most of these outcome goals (U.S. Department of Health and Human Services 2012c).

Safety

Maltreatment in Foster Care Though foster care should be absolutely safe for children all of the time, abuse or neglect does occur. Episodes severe enough to be reported, investigated, and founded are rare—three in every thousand children (U.S. Department of Health and Human Services 2012a). Youth who have been in foster care use a looser standard, and about a third of them tell us that they experienced treatment that felt like abuse or neglect to them (Pecora et al. 2010). Whatever the actual incidence, there should be absolutely no maltreatment of children in the safe haven of foster care.

There is relatively little literature on maltreatment in foster care, and much of it comes from twenty years ago. Zuravin and Benedict (1993) found kinship foster homes to be at less risk for maltreatment than regular homes and note that the family bond may be protective and that these homes are licensed for particular children and are not likely to be overcrowded. Other studies have found little difference (Hobbs and Hobbs 1999). Homes for which negative factors were noted at licensing, such as foster parent age, income, or health, were at greater risk, as were homes that were licensed only for a particular type of child; the authors suggest that these may be marginal homes, licensed because of the foster care shortage (Zuravin and Benedict 1993). In a review of the research literature, poor matching of children to foster homes, overcrowding, and absence of support from the worker were among the elements added as risk factors for maltreatment (Holder et al. 2003).

Careful selection and training of foster parents is the first element in protection of children. ASFA requires that foster homes meet certain safety standards, whether they are relative homes or nonrelative homes. When we know so little about the causes of maltreatment, however, it is difficult to know whether the most important elements are being targeted. Inadequate supervision of a placement is often considered responsible for abuse or neglect; mandating more frequent supervisory visits may be a partial remedy, and interaction with the children in the home at each visit is important. Basic is the worker's attentiveness to the needs of the foster parents and the consequent quality of the relationship.

Reentry into Foster Care Not all children who leave foster care leave permanently. Most children who reenter foster care are children who have returned to their original homes, only to have the family again become unable to care for them. In 2011, 11.8 percent of children who were discharged reentered foster care within twelve months of discharge (U.S. Department of Health and Human Services 2012c). Data from a Midwestern study show that 14 percent of children who had been in nonrelative foster care return to care within one year after reunification with family, as do 8 percent of children returned home from relative foster care (Wulczyn, Chen, and Hislop 2007). NSCAW data show approximately 20 percent of the children having at least one re-report of abuse or neglect (though not necessarily being readmitted to foster care); those in formal kinship foster care were least likely to be re-reported (Casanueva 2012).

Reentry into foster care may indicate that a child was returned to the family too soon, or without enough support, or with inappropriate services provided, or it may indicate that reunification was not an appropriate goal. Or it may occur due to changes in family circumstances after the child was back home, an outcome beyond the control of the child welfare agency. Reentry represents another placement and is destructive to a child's hopes of family reunion—another adverse experience for the child.

Studies based on samples and using case records or interviews with caseworkers as data sources have identified some of the factors associated with reentry into foster care. Neglect is more likely to recur than sexual or physical abuse (Jonson-Reid et al. 2010). NSCAW data identify children's behavior problems as an important factor (Barth et al. 2008), as did Block and Libowitz (1983) and Fein et al. (1983). Older age at placement also is related to reentry (U.S. Department of Health and Human Services 2012c). Children who had short stays in foster care are at risk for reentry (Kimberlin, Anthony, and Austin 2009; U.S. Department of Health and Human Services 2012c). Families dealing with a large number of problems were more likely to have a child reenter foster care (Kimberlin, Anthony, and Austin 2009). Not surprisingly, unmet service needs for the parents at the time of discharge coupled with limited planning for services to meet those

needs was associated with reentry (Festinger and Botsko 1994), while receipt of child welfare services lowered the risk of re-referral (Jonson-Reid et al. 2010).

Caseworkers have been good predictors of which children might reenter foster care (Fanshel and Shinn 1978; Block and Libowitz 1983; Festinger and Botsko 1994). This suggests that caseworkers are good judges of unmet service needs and that they are in a good position to mobilize community supports for families, both while children are in foster care and after they return home. The fact that caseworkers can predict the return of some children to foster care may also indicate that they are willing to take some risk in an effort to give children every possible chance of growing up in their own families.

Permanence

Permanency has been so emphasized in recent years that it is often the outcome measure by which agencies judge service effectiveness. In 2012, as shown in figure 6.4, 78 percent of the children leaving foster care left to go to a permanent home: 52 percent returned to their parents, 20 percent were adopted, and 6 percent were discharged to guardianship. Reunification with parents is most likely for children after short foster home placements; the likelihood of reunion diminishes after three years (Wulczyn 2004).

Adoptions from foster care are growing in number. Until the mid-1990s, the percentage was fairly stable; about 10 percent of the children leaving foster care left for adoption between 1980 and 1996. In 1996, 28,000 children were adopted from the foster care system (Evan B. Donaldson Adoption Institute 2002); by 2012, this number had increased to 51,229 and accounted for 21 percent of the children leaving foster care (U.S. Department of Health and Human Services 2012b). Adopted children tend to be young. Though only 2 percent of the children adopted from foster care in 2012 were under 1 year of age, 57 percent were under 6. Foster parents adopted 56 percent of those whose adoptions were finalized in 2012. Thirty percent were adopted by relatives, some of who were also foster parents (U.S. Department

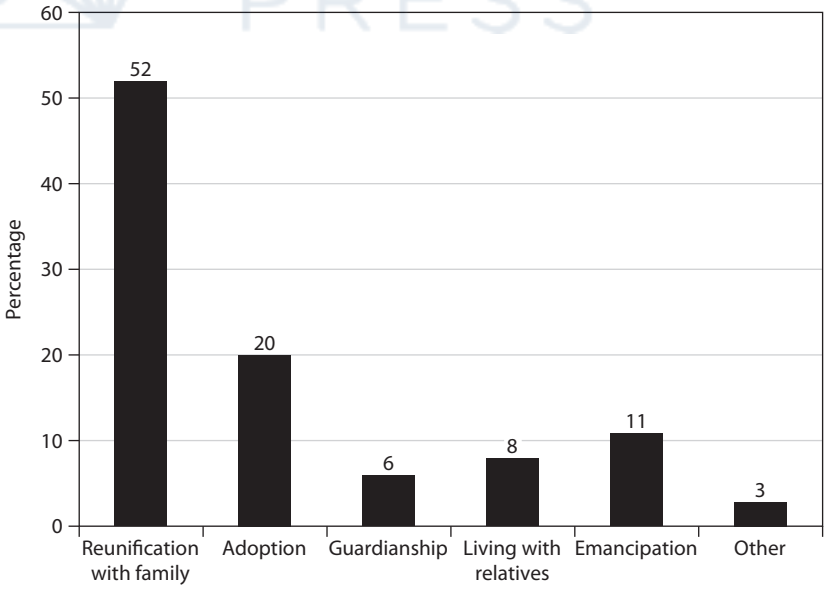

FIGURE 6.4. Reason for discharge from foster care *Source:* AFCARS 2012 (U.S. Department of Health and Human Services 2013)

of Health and Human Services 2012b). Thus, recruitment of new adoptive homes was necessary for only 14 percent of the children who were adopted.

States seem to be least successful in moving children with diagnosed disabilities and older youth into permanent homes (U.S. Department of Health and Human Services 2012c).

Well-Being

Well-being is the third federal outcome measure. It is a critical measure, for if the state is to take custody of a child, it becomes responsible for providing the nurture and guidance that a child needs for optimum development. It is also harder to measure than safety or permanency. Major components of well-being are success in education and work toward resolution of any physical and mental health difficulties.

Education The educational outcomes for children in foster care are poor. Physical and emotional/behavioral problems, disrupted living environments, and frequent moves have left children behind as they enter foster care. They exit foster care still behind, due in part to the moves and changes of foster care itself (Fanshel and Shinn 1978; Courtney et al. 2007; Pecora et al. 2010). The Fostering Connections to Success and Increasing Adoptions Act of 2008, with its provisions on providing continuity in education, articulates this responsibility. Education is a part of children's lives that foster parents understand, and they are usually good advocates for their children in the school system.

Mental Health We have good descriptions of mental health needs of children in foster care, information on the percentage of children (80 percent) connected to mental health services (McCarthy and Woolverton 2005), and some information about the degree to which these services meet needs, including the positive impact of mental health services (Fanshel, Finch, and Grundy 1990). Longitudinal case-level data are needed, and as the NSCAW study progresses this need may be met.

Physical Health Generally, foster care systems are well organized to see that children receive routine immunizations, well-child care, and medical care for illness and accidents. Care is usually through general practitioners who will accept Medicaid reimbursement rates. Results from Child Welfare Service Reviews show that 85 percent of the children in foster care receive physical health care (McCarthy and Woolverton 2005).

Approaches to Discovering Outcomes

Developmental Progress in Foster Care An excellent measure of the outcome of foster care is longitudinal tracking of children's progress from the point of entry to discharge. The focus of these studies is on the impact of foster care itself—whether it is remedial, destructive, or essentially has no impact.

The best known of these is a five-year longitudinal study of 624 children who entered foster care in New York City in 1966 and remained for at least ninety days in foster care. Data were collected ninety days after entry into foster care, approximately 2.5 years later, and after 5 years. It seems like very old data now, but for children, foster care itself has not changed that much.[12] Mental health status was measured through psychological tests. The investigators expected deterioration in longer placements but found it in only a few children, with more showing improvement. Visits from parents were important, and children did best in foster homes where parenting practices were flexible and rather permissive. Overall, on all the dimensions measured, the investigators concluded that children's status at discharge reflected their status at entry (Fanshel and Shinn 1978).

A major study published in 1990 used record reading to develop a longitudinal look at youth in care (Fanshel, Finch, and Grundy 1990). Data were gathered from records on the child's status at entry into care and at midpoint; at discharge,

records were supplemented by interviews with the youth. The young people entered care with the range of problems described earlier in the chapter. Investigators found evidence of the pervasive impact of some events prior to coming into care, particularly abuse and delinquency. However, their data indicated that services during placement that resulted in improved mental health and behavioral change had lasting effects. (They also noted that records dictated by caseworkers contained very little reference to the parenting practices of the foster parents.)

Looking at more recent data, a 2009 longitudinal study of fifty-nine children in long-term foster care in Australia found that "despite concerns related to emotional and behavioral outcomes, academic achievement and placement stability, modest and consistent patterns of improving outcomes were evident, supporting the positive trends in resilience research" (Fernandez 2009:1100). Again, parenting styles were important, with problems in responsiveness and warmth being linked to lack of academic progress, health problems, and poorer overall adjustment.

Adult Functioning The final way of thinking about outcomes is to examine the adult functioning of former foster children. Adult functioning is the ultimate outcome of foster care, though of course multiple variables in addition to foster care affect this outcome. There have been, over the years, many studies of how former foster children have fared as adults. These are reviewed at the end of the following chapter, as they generally include group care in their sample.

The outcome of foster care for the family in our case example is not as positive as might be hoped. Again, the timelines of reunification of children with parents in child welfare are not congruent with the timelines of recovery from substance abuse, as discussed in chapter 2. Note also in box 6.11 that the parent is discussing her difficulties with the foster parent rather than her worker.

BOX 6.11

Ms. W.'s children are still in foster care. Her boys were home and the baby was making weekend visits when she relapsed in her recovery from substance abuse. She told the foster mother that she was "tired of it all." She missed court hearings and seemed resigned to losing her children. Relapse is part of the recovery process. The worker wondered if it occurred because the responsibility for all of the children seemed too great. The uncertainty about eventual prognosis is great.

Currently, it is planned that the court will be asked to make an exception to the ASFA timelines for the boys, who have a long-term relationship with their mother, and allow her more time to establish a home for them. The baby is probably headed for adoption, perhaps with the foster family or perhaps with another family.

The story of this family and their experiences in foster care are not unusual.

Critical Issue: Establishing and Retaining Foster Homes to Meet the Needs of Children

If the foster care system is to be preserved it must be strengthened, and that will require renewed investment in every aspect of the system. It begins with improved recruitment, assessment, and retention of foster homes, so that good homes will be available to meet the varied needs of children who come into care. Adequate supervision and support of the homes is necessary, so that children can receive excellent foster care. The system should differentiate its foster homes and provide training opportunities for foster parents that want to develop particular skills for working with children with special needs or for working with parents. Above all, we need to respect the wisdom of foster parents and value their input in the process of planning permanency for children.

Recruitment of Foster Parents

The process of recruitment involves reaching into communities to find families who might

be foster parents. Agencies use a variety of means, including television "spots," newspaper articles, billboards, and presentations to church congregations and civic groups, to raise general awareness of the need for foster parents. Targeted recruiting—which publicizes an agency's efforts to find care for specific children or for a particular category of children, sometimes using pictures of actual children who need foster homes—is often more successful in drawing the type of family that is needed. The most effective recruiting, however, is word of mouth—foster parents sharing their experiences with people they know.

Children need to be placed in culturally appropriate homes, where they know the language, the food is familiar, and the ways of social navigation seem comfortable. A large, multistate study of foster care identified the recruitment of minority foster homes as a major need (U.S. Department of Health and Human Services 1995). Extensive recruitment efforts in the following years may have had some impact; one indicator is that most of the children in the NSCAW sample were placed in same race/ethnicity homes (U.S. Department of Health and Human Services 2001).

There are agency barriers to the recruitment of homes of color. Many foster parent recruiters are white, middle-class women. As they try to engage families in racially diverse communities, they may encounter resistance stemming from historical distrust both of white people and of social service agencies. African American recruiters have been significantly more successful in recruiting families within the black community. The issue is systemic: one long-term approach to the shortage of minority foster homes is to address the lack of ethnic diversity among workers throughout the child welfare system. The problem perpetuates itself because with relatively few foster families in a given cultural community, there are fewer opportunities for the most effective form of recruiting—word-of-mouth.

Assessment

During the assessment process, the agency seeks to ensure that a potential foster home meets minimal standards for health and safety and to engage the family in examining its own suitability for fostering. Criteria for selection of foster parents have traditionally been more relaxed than those for selection of adoptive parents; in this era when many foster homes provide care for several years and many foster parents adopt, this distinction must be questioned.

Some of the characteristics most commonly sought in foster parents are affinity for children, flexible expectations, ability to view children as unique individuals, a realistic picture of the difficulties of children needing placement, and a willingness to adapt to the needs and characteristics of such children. Other attributes include good enough health to have the energy to parent a sometimes difficult child, interest in learning—about medical needs of a child, about behavioral problems, about ways to parent in response to particular difficulties—and finally a commitment to children and a demonstrated ability to use a variety of coping techniques to see difficult situations through to resolution.

The requirements for licensure of foster homes in each state include certain minimal physical attributes of the dwelling. These requirements sometimes make it difficult to develop foster homes among poor communities and can constitute a systemic barrier to finding culturally appropriate foster homes. ASFA requires foster parents to undergo a criminal background check; there is variability among states in precise regulations. Though social workers may see these as routine, it may be an unexpected and potentially demeaning requirement for many applicants. Workers must be prepared to present this requirement as a universal precaution taken for the safety of all children in the system. Agency policy should be clear about how the results of such a check will be used and under what circumstances exceptions can be made to certain rules.

Philosophies and regulations regarding the discipline of children can present another impediment to the establishment of a culturally diverse foster home. Child welfare agencies have policies concerning acceptable methods of discipline to be used with foster children; their rules generally prohibit the use of physical punishment and certain other punitive forms of discipline. Some families are accustomed to using physical discipline and will need to learn new methods, and to see that these methods are effective, before they are comfortable with agency policies. Acceptable methods of discipline vary among cultures, religions, and ethnic groups; therefore, this issue will affect some populations more than others.

As they work to overcome the overall shortage of foster parents and the relative lack of diversity among them, policy makers must examine all of these factors. Triseliotis suggests that the worker must be open-minded, "looking at whether applicants will be able to meet a foster child's needs, not whether they will be able to meet them in a particular traditionally acceptable way, and looking at whether families function successfully, not whether they function in a way which might be expected from a Eurocentric perspective" (Triseliotis, Sellick, and Short 1995:80).

Training

Training of foster parents takes many forms. Initial training is often part of the assessment process, as worker and parents together decide whether expectations and resources of the applicants meet the needs of the agency. Ongoing training involves periodic focus on specific aspects of foster parents' work and is part of the package of support services that agencies should provide for foster parents.

Initial training has two goals: (1) it is an opportunity for the prospective foster parents to complete the self-selection process, as they learn more about the characteristics of children who need foster homes and are encouraged to evaluate their own capacity to work with these children, and (2) it teaches foster parents new ways of thinking about foster children, their families, and the issues they bring to placement, as well as specific skills that will help them to manage problem behaviors.

There are multiple training programs available for foster parents. Most contain material on understanding the developmental needs of children, developing a realistic picture of the children needing foster care, and effective parenting practices. A common way to deliver this training is through group meetings, where discussion among participants helps them understand the material. Online training is also possible and is particularly useful when distances are great.

In an extensive review of the research on aspects of the foster family that exacerbate behavioral or emotional problems in children or prevent or ameliorate problems, Orme and Buehler (2001) identified parenting styles that are associated with children's emotional and social adjustment. These include high levels of parental acceptance and lower levels of harsh discipline and control. Preferred parenting styles can be assessed during training, and training itself has an effect on parenting behaviors. These assessments of the "style" of the prospective foster home can help a worker make a placement where child and foster family will thrive together.

Initial training starts foster parents on their adventure. As they gain in experience, however, more advanced training can help them deal even more effectively with the complex needs of foster children in their care. Foster parents also sometimes become "specialists" in one type of foster care and may need specific training for that type of care in order to become maximally useful to children. For example, foster parents who decide they are interested in parenting medically fragile children need specific training in techniques of nursing, use of medical equipment, and the meaning of illness and disability to children, while foster parents who decide they wish to parent older, troubled

children and youth need help with understanding the dynamics of behavior and with behavior management techniques.

As knowledge builds, new information needs to be shared with foster parents. For example, new understanding of the changes in brain development that occur with prenatal exposure to alcohol, or with having needs consistently ignored, or with living in a frightening household leads to profound change in the way in which consequent behavior is best managed in the foster home. Foster parents need ongoing training that enables them to share in these developing insights, as well as opportunity to integrate earlier information with their new experiences. This ongoing training is viewed as an important support service by foster parents (McGregor et al. 2006; Geiger, Hayes, and Lietz 2013).

Retention of Foster Homes

Retaining good foster parents is critical and should be a top agency priority of any child welfare agency. It is hard to recruit foster parents and expensive to assess and train them. A good foster home is a tremendously important resource for children who need care. A foster home that stays with the agency offers the possibility of single placement for the child currently in care, possibly a permanent placement, and the opportunity to provide for many other children.

Too many foster parents withdraw from fostering after only a brief time. Turnover among foster parents is estimated to range between 30 and 50 percent in some agencies (Christian 2002, as reported in Gibbs and Wildfire 2007). A study using administrative data from three states found median length of service of foster parents was eight months in two states and fourteen months in the third, with only a quarter to a third of foster parents remaining more than two years. A few foster homes provided most of the days in care—the most active 20 percent of foster homes provided between 60 and 72 percent of all days of foster parenting (Gibbs and Wildfire 2007).

There has been remarkably little query of these foster parents to discover the reasons for their withdrawal. A multistate survey of 827 former foster parents found that 37 percent had stopped fostering because of specific agency policies and 24 percent because of behavioral problems of children. Former foster parents also reported less satisfactory interactions with their caseworkers than did current foster parents (U.S. Department of Health and Human Services 1995). Though this is an older study, the reasons given are echoed in more recent work in which smaller samples of current foster parents were asked what would make them stop fostering (Denby, Rindfleisch, and Bean 1999; U.S. Department of Health and Human Services 2002b).

A series of studies asked current foster parents about the rewards and trials of fostering (Denby, Rindfleisch, and Bean 1999; Seaberg and Harrigan 1999; Rhodes, Orme, and Buehler 2001; U.S. Department of Health and Human Services 2002; Buehler, Cox, and Cuddeback 2003; Brown and Bednar 2006; MacGregor et al. 2006; Rodger, Cummings, and Leschied 2006; Shireman 2009; Geiger, Hayes, and Lietzx 2013). The responses were remarkably similar.

Feeling Successful Nobody stays with a task unless he or she feels successful. Foster parents noted that the rewards that foster parents perceive are tied to their motivations for fostering. In interviews with foster parents, themes of making a difference in a child's life and watching them grow and develop were articulated as rewards. A "wrong" motivation, such as increasing income, which was not likely to be realized, made a foster home less likely to succeed (Buehler, Cox, and Cuddeback 2003). Foster parents discussed discipline, structure, and deep empathy for the children as ingredients of successful fostering.

Foster parents, faced with difficult children and new situations, need continued support and help. One frequently mentioned need was help in finding and accessing mental and physical health services for the foster child. Respite

service to prevent "burnout" was another frequently mentioned need. Continued training in handling new situations, such as having a child leave to return to parents or to be adopted, was also frequently discussed (Geiger, Hayes, and Lietz 2013).

Partnership with the Agency The social worker–foster parent relationship is without question a major factor in retention of foster homes, and one that the agency can influence. Foster parents report varied satisfaction with this relationship; satisfaction seems to hinge on a worker's supportive interaction, timely response to appeals from the foster parent for help, and on a worker's inclusion of the foster parent as a "partner" in caring for the child (Shireman 2009).

Unfortunately, caseworkers are often inaccessible. Response to foster parents does not happen consistently. In a survey of foster parents, only half indicated that workers returned telephone calls within forty-eight hours of the call (Shireman 2009). Foster parents have reported that caseworkers did not return their calls for days or weeks, and even then being slow to provide needed help; caseworkers tend to agree with this assessment, blaming multiple responsibilities and high caseloads (U.S. Department of Health and Human Services 2002b).

Parenting a foster child exposes the foster parent to situations with which there is no experience—children may be exhibiting behavior that is disturbing or even dangerous, and usual parenting techniques seem to bring little response. As one foster parent described the situation:

> When the first violent episode occurred, I couldn't sleep. I phoned three different people. One person called me back in the morning. I was so upset. I shouldn't have been alone. They should have been there to support me. (MacGregor et al. 2006:360)

The other critical aspect of the relationship with the social worker identified by foster parents was the importance of being treated as a partner in nurturing the child. Foster parents need information, particularly when a child is first placed, and want the worker to share everything that is known. Withholding of information, either because of confidentiality concerns or because the worker is trying to paint a more attractive picture of a child, is viewed as a statement that the foster parent has a lesser status. It also handicaps the foster parent in dealing with the child. Foster parents think, understandably, that after the child has been in their home for a time, they know the child better than the worker does. They want to have a voice in decisions regarding the child's care, both decisions that have immediate impact and long-term planning. Again, experiences varied:

> These are very damaged children. I have had to fight every single step of the way to get them therapy and educational support. (MacGregor et al. 2006:360)
>
> [The caseworker] has always told me my opinion is of great value. . . . She always asked what my opinion was, and she always made me feel that I was a part of the puzzle. All the time. I never expected it, but it did happen. I was impressed. (Shireman 2009:18)

Foster parents want to be part of the major decisions in a child's case plan—should he go home? Should he be moved to another foster home or to group care? Should he be adopted? As they care for children day to day, foster parents learn a tremendous amount about the children and their needs. They often have opportunities to observe the child in interactions with family members. Sometimes they themselves have had extensive interaction with relatives of the child. When it is time to plan for the child, the foster parent has a great deal of useful information to share. Thus it is important that foster parents have ample opportunity to talk with workers and express their ideas. It is important that they be invited to meetings

where professionals are discussing plans and to case status reviews by court-appointed reviewers. It is important that they be present as the information and perspectives they provide are discussed, evaluated, and woven into the perspectives of others.

Even so, it is not usually possible for foster parents to act as equal partners in decision making about the child. They should be listened to, their information should be valued, and their perspectives should be given weight. However, if the child welfare worker and the foster parent disagree about planning for a child, the authority of the agency will back the child welfare worker. The court will, of course, be the final arbiter of disagreements over decision making. Foster parents are gradually gaining the right to participate in court hearings in some states, but unless the foster parent is an actual party to a contested custody case, foster parents often have little opportunity to speak directly to the court.

Strong Support Systems Foster parent support systems extend beyond the child welfare system. Extended family, neighbors, friends, and churches form a network providing help, advice, emotional support, and intermittent child watching. Their approval and encouragement can be vital.

Foster parent support groups can be of great assistance in solving everyday problems. It is wonderful to experience a group of foster parents together. Busy people, they do not see each other frequently. But they share an experience shared by no one else. As they trade ideas about ways to handle problem children or problem social workers, one can see ideas spark, new resolutions being formed, and new paths of action opened. There is renewed energy and a sense of mutual support. The benefits are documented in the findings of a study of current and former foster parents: 31 percent of those who continued to foster, but only 13 percent of former foster parents, had another foster parent on whom they called for support. Continuing foster parents were also more likely to have joined a foster parent association (U.S. Department of Health and Human Services 1995:85). Seaberg and Harrigan (1999) noted that 75 percent of the 124 foster parents surveyed turned to other foster parents for consultation about foster parenting, and McGregor et al. (2006) found a common theme of the need for foster parents to support each other.

Adequate Compensation Payment for foster care has been a subject of controversy since Charles Loring Brace reacted to the idea with the statement that parents should foster out of "love and charity" and that introducing the idea of payment would distort the foster parent–child relationship. That argument, plus the budget consciousness of legislatures, has kept foster care payments pegged to the cost of feeding and clothing a child—barely adequately—unless the child has particular problems that are deemed to merit a supplement. Foster parents are still caring for children out of "love and charity."

Caring for a child entails many expenses beyond food and shelter. Many states do not pay for child care, an omission that has become an increasing disincentive to fostering as more women enter the labor market. Clothing allowances are inadequate, particularly for teenagers for whom issues of self-esteem come into play. If a foster family sees as a necessity something the agency deems a luxury, the parents may resent the agency for questioning their judgment as well as for failing to meet the child's needs. Special lessons or experiences to enable children to develop their own talents are too often viewed as unnecessary by agencies concerned about budgets, about equity, or about affording children advantages they would not have in their own homes. The needs of particular children are too often met out of the budgets of the foster parents.

Foster parents are reimbursed for their expenses in caring for the foster children at

a very basic level. Agency budgets dictate the low levels of reimbursement that foster parents receive, and public perceptions reinforce this. Notably, a recent survey found that the public thinks foster parents receive salaries in addition to expenses for child care (Leber and LeCroy 2012). There is concern about foster parents who do not have adequate income to support the family and rely on foster care payments. Smithgall, DeCoursey, and Goerge (2008) detailed some of the compromises made in these families and the adverse effects on the provision of a range of childhood experiences. Many foster parents are employed, and these parents stress a need for help in paying for child care if they are to continue to foster (Rhodes, Orme, and Buehler 2001).

Foster parents tell us that generous policies for meeting the child care expenses of foster parents and generous compensation for the skills needed to deal with particular problems that children present would improve both recruitment and retention of foster parents. Social workers, though they often have altruistic motives for entering the profession, work for an income. Why should foster parents not also work for an income?

Almost as important as the rate of pay and reluctance to fund the special expenses is the manner in which foster parents are paid. Too often they must justify expenses, plead with administrators, cope with rejected requests, or get paid months after the expense has occurred. This process creates a dynamic in which the foster parent begins to view the agency as an obstacle to the good care of the child—not a perspective that is conducive to partnership with the agency in planning.

Foster parents who take on difficult children or many children are customarily compensated at special rates. These rates are more commensurate with the expenses of raising a child and with the time the foster parent will spend with the child. The rates usually accompany added responsibilities, such as taking children to therapeutic appointments, advocating for children in special school settings, carrying out particular behavioral regimes at home, and/or working directly with the biological parents. These foster parents become more truly partners with the agency in caring for the child. Such a combination of higher reimbursement rates and expanded responsibilities might be a better approach to all foster care.

Continuing Fostering Foster parents identified the following issues when directly asked, "What would make you consider stopping fostering?"[13]

- Problems with the child welfare department, explained as negative interactions with the caseworker, or limited caseworker accessibility and support. High caseworker turnover was noted as a problem.
- Perception of low importance by others, indicated by low board rates, failure to share information about a child, and not being notified of reviews or invited to agency decision meetings.
- Stress, safety (mostly concerns about the threats a foster child poses to other family members), and health. Stress can come from inability to find support and help for problems of fostering. Unmet needs produce stress: foster parents identify a need for respite care, a need for child care, and a need for more help in accessing medical and dental services. They also worry about false allegations of abuse and consequent investigations. Stress can also come from poverty, from health concerns, and from events in the lives of the foster family and its own networks.

Many of these difficulties are under the control of the child welfare agency. The overall message is that additional responsiveness to foster parent requests, attempts to provide support and meet needs, and a willingness to view foster parents as partners could lead to more success in retaining foster homes.

Conclusion

This chapter's review of the history of out-of-home care showed that the shortage of placements for children who need care is not new. Early orphanages eased the pressure on their capacity by indenture. Cities sent children to rural areas. The advent of foster care created seemingly limitless family resources for the care of children, until demographic changes, increasingly high community standards for the treatment of children, and poverty and substance abuse all coincided to increase the number of children needing care while decreasing the number of available foster homes.

The consequences of the current shortage are many. Agencies place children in an available foster home rather than carefully matching their needs with the strengths of the home. Placement failures result, children are moved often, and each move damages the child's sense of trust and ability to form lasting relationships. The continual workload pressure on child welfare workers limits their capacity to supervise foster homes and to support foster parents who are caring for difficult children. In the worst of cases, the result can be abuse or neglect of the foster child.

In response to the shortage of foster homes, the child welfare system's efforts have been focused on reducing dependence on foster care—at best through keeping children in their own homes through intensive services to the family or, when there has been a placement, moving children back home or into adoptive homes as quickly as possible. Policy initiatives leading to increased placement of children with relatives in kinship foster care have eased the pressure on foster homes. These are the tenets of family preservation and permanency planning and are good policy. Missing is the work and investment needed to strengthen foster care.

The investment itself has the potential to relieve the shortage of placements. Too many foster parents leave the system after very few years. Better supportive services are part of the solution, and adequate compensation would help. But probably the greatest need is for the creation of an atmosphere in which foster parents are treated with courtesy and respect, know their foster children's caseworkers and, if appropriate, the children's families, and are truly partners in decision making. Foster parents are remarkable people, and they deserve to be cherished.

Foster care is impermanent and is a long-term plan only in special circumstances and with special protections, such as guardianship, to ensure stability. If we invest in it, however, it can be a much needed crisis service. The goal is for each child to have only one placement, during which developmental needs are assessed, needs met, and services provided, while active work with the biological family and the foster family occurs, and everyone together develops and implements a permanent plan for the child.

NOTES

1. There is little record of children being removed for abuse, doubtless because of the severe physical punishment that was considered normative.
2. Esther Forbes, in her novel *Johnny Tremain* (Boston: Houghton Mifflin, 1943), presents a story of an indenture that displays both its potential advantages and its dangers.
3. The reader should be careful not to judge the work of this reformer by the standards of the current century. Reading Brace's own writing provides the context of the time.
4. The same relocation of children from cities to homes in the countryside took place over even greater distances through Barnardo's, a child welfare agency in Britain. Children from Great Britain were transported to Canada and Australia. The last of these "shipments" of children occurred in the 1950s. The heartbreaking stories of many of these relocated children highlight the need for supervision of family homes by the placing agency. See P. Bean and J. Melville, *Lost Children of the Empire: The Untold Story of Britain's Child Migrants* (London: Unwin Hyman, 1989).

5. This low rate of placements explains in part the difficulties, discussed in chapter 5, of using experimental design to evaluate family preservation services.
6. About a quarter of the placements are less than six months; 5 percent less than a month.
7. McCarthy and Woolverton (2005) and Pecora et al. (2010) identify and summarize the studies of health and emotional developmental problems; Elze et al. (2005) is a comprehensive review of educational needs.
8. Pecora (2009:210–13) contains a concise and well-referenced review of these studies.
9. Karen Swift in *Manufacturing Bad Mothers* (Toronto: University of Toronto Press, 1995) presents a classic critique of the way in which a child welfare investigation defines a mother.
10. It is difficult to understand the preferences expressed by the children in this study, with 67 percent of the children expressing the preference for biological family that seems to be common in other studies of foster children, while more than half of the children over age 11 express a preference for the foster home as a permanent home. It is mathematically possible, but difficult to reconcile.
11. A difficulty with this NSCAW data is that "caregiver" is not defined. Children were asked their response to "primary" and "secondary" caregivers, but that distinction was not carried into the reporting of the characteristics of foster parents. This makes interpretation of some of these data difficult—for example, if 40 percent of caregivers do not work, is there a second foster parent supporting the family or is income solely from public sources?
12. One interesting statistic that might make a difference in the foster care trajectory of these children is that only 14 percent were placed for reasons of neglect or abuse. Mental illness of the child-caring person was the major reason for placement. Though described in different terms, the difficulties of the children at entry to foster care seem similar to those reported today.
13. Responses cited are from Denby, Rindfleisch, and Bean (1999); Rhodes, Orme, and Buehler (2001); Office of the Inspector General (2002); MacGregor et al. (2006); and Geiger, Hayes, and Lietz (2013).

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7

Out-of-Home Care for Children with Special Needs

I am often asked by my friends, who think the child is little more than half-witted, why I do not "send her back and get a brighter one." My answer is, that she is just the one who needs the care and kindness which Providence has put it into my power to bestow. We love her dearly.

—A foster mother in Ohio, 1859[1]

In the preceding two chapters, we have examined regular family foster care and kinship foster care. These types of foster care are the most frequently used types of out-of-home placement and are appropriate for children whose primary needs are safety; a nurturing, stable home environment; and assistance in overcoming the challenges of their early years. Children have, however, a variety of needs, and sometimes their care is beyond the skills of regular foster parents.

Serious physical and mental health problems require special management as well as remedial therapies. Specialized foster homes have developed to meet the needs of these children, both medical and therapeutic foster homes. And some children cannot manage family life and need the structure and intensive services of group care. This range of services forms a continuum of care for children, and many children move from one type of care to another as their needs change. Building on the chapters describing kinship foster care and traditional family foster care, this chapter will add to the exploration of out-of-home care resources.

In this chapter, we turn attention to children with special needs who are being cared for outside of their own homes. These children, like the children in regular foster care, usually come from backgrounds of poverty. African American children are overrepresented. Many have experienced abuse and/or neglect at some time in their lives. Many have disabilities; some children are physically fragile or have chronic illness and have extensive medical needs. Some have developmental disabilities, usually defined as an IQ score less than 70. Mental health difficulties are common. Some of these children came into the foster care system as adolescents because of emotional or behavioral difficulties too severe for their families to manage.

Children with disabilities are thought to be overrepresented in out-of-home placement, though there has been little attempt to identify them in child welfare data systems.[2] Though most disabilities with a medical basis are recognized in preschool years, learning disabilities and emotional/behavioral difficulties are often first identified in the classroom and occur on a continuum, from mild to those that prevent functioning in major life tasks. Disability has been identified as a risk factor for maltreatment, a beginning explanation for its prevalence in foster care. Mental health problems may become disabilities as they persist, and the trauma to which almost all in foster care have been exposed predisposes youth to disabling mental health issues. Studies that use special education status as a proxy for disability consistently show that 30 to 40 percent of youth in foster care experience a disability (Greenen and Powers 2006), as do a third of those in residential care (Chmelka et al. 2011). Youth with disabilities compose the majority of those aging

out of care (Hill 2012), and transition services are often not tailored to the needs of youth with disabilities (Greenen et al. 2007)

Children and youth with disabilities may be placed in regular foster care, treatment foster care, and residential care. Despite the definitional difficulties, children with disabilities need to be better identified in the child welfare system, both because of the need to be sure their needs are met and because of their entitlement to special supports under the Individuals with Disabilities Education Act of 2004 (IDEA).

This chapter explores the child welfare system's attempts to expand and diversify its out-of-home care resources, creating a continuum of care so that each individual child's needs can be met. The chapter attempts to illuminate the complexity of the task of matching these children, with their many needs, to appropriate resources and ensuring that any moves from one type of care to another are appropriate and backed by adequate community support. The critical issue of all out-of-home care is explored in the final section of the chapter—what is the outcome?

Shelter Foster Care and Assessment Centers

Protective service units continually face situations in which children need immediate placement. Sometimes these are emergency placements in which there have been no opportunities to get to know the family or the child. It can be very difficult to find a regular foster family willing to take a child in an hour or two and even harder to find one that has the capacity to absorb a sibling group. The shortage of foster homes has compounded this problem, and one solution is the creation of shelter foster homes and/or group shelter facilities. These provide an immediate short-term residence for the child and a chance to get to know the child.

Shelter Foster Care

Shelter foster homes, sometimes called emergency foster homes, are family homes that are ready to take a child at any time of day or night and to care for the child for a brief time. Usually, the placements are intended to last no longer than two weeks. Shelter foster homes are often salaried, as their beds will of necessity be empty at times if they are to retain the capacity for emergency placements. Typically, they are licensed for up to five children.

Foster parents who take in children for emergency shelter care must be ready to recognize and confront the fear and anxiety of children who have been removed from their homes abruptly and thrust into a strange environment. Children removed in emergency situations often show signs of severe neglect or abuse; foster parents can be very angry that parents would allow such things to happen to children. One of the tasks of the social worker is to recognize this anger and help the foster parents deal with it, because it will be important for the children to have visits with their parents or former caretakers very soon. Another task of the worker, carried out in conjunction with the foster parents, is the assessment of the child's needs. When children come into shelter care, very little may be known about them. A great deal must be learned in a brief time in order to maximize the possibility that the next placement will be the last out-of-home placement a child will experience. Prompt and thorough assessment is particularly important when children have disabilities.

Aside from those relatively rare occasions when a child is discovered to be in real danger in the current home, emergency placement is likely to be an indication of the system's failure to work productively with parents or foster parents so that a placement can be avoided or, if necessary, made in a planned way. However, there are emergencies, and a comfortable home that will welcome a child is far better than sitting in a worker's office or riding in the back of a police car while a placement is located. Whether the existence of shelter foster care (and assessment centers) increases the number of emergency placements is an interesting and unanswered policy question.

Assessment Centers

Group shelters, or assessment centers, of varied sizes exist in many communities. Typically, they are isolated from the community, providing care and schooling within their own walls. Their role is to take in children on an as-needed basis and to care for them during a brief time (usually two weeks) while an assessment is completed and the next steps in care are planned. One advantage of assessment centers is that they can usually take sibling groups, thus providing some support and continuity for children. They are staffed by rotating shifts, so that there is little continuity of caregivers, a particular liability for young children if the stay is longer than a matter of days.

Assessment of the child's needs takes place during the time in the assessment center. A multidisciplinary staff provides medical examination, psychological testing and consultation with a psychologist, an educational evaluation, and assessment of social skills made through observation of a child's behavior. The thoroughness of this assessment is one of the advantages of group shelter care. The assessment is then used in selecting an appropriate placement resource for the child: a family foster home where the "match" of a child's behaviors and family skills is good, a treatment foster home where remedial work can begin, or one of a range of possible residential settings.

Assessment centers are controversial, in part because it means that every child will have more than one placement. Advocates point to the advantages of a thorough assessment of each child so that a long-term placement can be planned that will meet the child's needs. Opponents point out that with foster homes so scarce, such careful matching is unlikely to occur, and because it is difficult to find a foster family, the shelter facility may become the setting for a long stay.

Ten years ago, an issue on the horizon in child welfare was the question of group care for young children. As was noted in chapter 2, scholars agree that institutional care carries a developmental risk for very young children (Freud 1944; Bowlby 1951). The opening of Romania to the world after the collapse of the Communist regime in 1989 brought to the world's attention the adverse impact of poor institutional care on young children. The consensus has remained that group care does not meet a young child's developmental needs. One of the findings of a study of children in group care in California was that, although shelter placements for young children were designed to be brief and for the purpose of assessment, the median length of stay was more than a year (Berrick et al. 1997). As a consequence of findings such as this, one of the outcome measures of the Child and Family Services Reviews (CFSRs) is reducing the placement of young children in group care. Generally this has happened, but there is considerable variability among the states. The outcome data for 2011 show that though the national median is 4.5 percent of young children placed in group care, for eight states between 10 and 20 percent of children under age 12 are still being placed in group care (U.S. Department of Health and Human Services 2012c). There is no readily available information on how long these placements are.

Care for Children with Special Difficulties in Foster Care

Children are placed in specialized foster homes when they have needs that cannot be met in their own homes or in a regular family foster home and when the restrictive setting of group care is thought unwise. The nature of the child's needs dictates the appropriate placement. Specialized foster homes care for children with serious medical problems, and they care for children with serious emotional and behavioral difficulties. Foster parents are specifically trained for this work. The special needs of such children may be apparent at the time the child first moves into out-of-home care or they may become evident through a series of failed placements in regular foster homes.

Specialized foster homes for children with severe emotional/behavioral difficulties evolved from three discrete traditions: (1) traditional foster care, delivered in the foster care system, (2) residential treatment delivered through the mental health system, and (3) secure detention, administered by the juvenile justice system (Dore and Mullin 2006). Homes for children with severe physically based disabilities came from the deinstitutionalization movement of the 1980s, when large, custodial institutions were closed and children moved to smaller, community-based institutions or foster homes. These create a community-based alternative for children with serious emotional disturbance, medical needs, or developmental delays, who might otherwise be placed in more isolated institutions. They are part of the continuum of care, and children may come from or exit to hospitals, residential care, or family care. They are defined by the following characteristics:

- Children are placed with families selected and trained to work with children with special needs who would otherwise be admitted to an institutional setting.
- The home is a part of a program explicitly identified as a specialist or treatment foster care program with a name and budget. Typically, only one or two children are placed at a time.
- Payments are made to caregivers at rates above those provided for regular foster care.
- Specialized training and multiple support services are provided to the specialized foster parents.
- The treatment foster parent is considered a member of a service or treatment team

(adapted from Hudson, Nutter, and Galaway 1992; Jivanjee 1999; Dore and Mullin 2006).

A child may need a group setting to stabilize behavior or a medical condition and then be able to function in a specialized foster home. Or the foster home may be a point of transition from a residential setting back to the original home. Or the foster home may itself be the sole placement a child needs. As always, this type of out-of-home care is accompanied by services to strengthen the family and follow-up services to help child and family live together again. If reunification is not possible, planning is done to move the child toward adoption or toward some other plan for long-term support and care.

Medical Foster Homes

Families caring for children with serious medical problems are usually designated as medical foster homes. These homes often care for medically fragile infants and young children who have disabilities such as drug or alcohol exposure, genetic defects, chromosomal disorders, failure to thrive, feeding issues, and/or respiratory complications. The children usually require 24-hour supervision. These foster parents receive medical training and are amazingly competent at managing complex daily care as well as medical crises. Many of the children become sturdy enough to return to their homes or to move on to adoptive homes. Some, however, remain for long placements.

Related to the medical foster homes are the foster homes that care for developmentally disabled children. These are children who may have mental retardation, epilepsy, autism, or cerebral palsy. Again, the homes receive training specific to the needs of these children. These children will require assistance with daily living skills, close supervision, planning for early childhood intervention, and work with schools to develop appropriate individual educational plans (IEPs) as the children grow older. Fostering requires commitment to the children and to their developmental growth.

These foster homes develop close alliances with the medical community, the early education programs, and later the schools. They need continual support from the child welfare system in negotiating these resources, as well as

in maintaining their commitment to the child. Respite care, described in chapter 4, is often a critical resource for these foster families. As the primary interactions of these foster parents are with the medical system, the schools, and the developmental disability system, they have received little attention in the child welfare literature.

One foster mother we know described the medically fragile infant she is fostering, whose medical problems and difficulties with hearing suddenly seemed overlaid by a possible long-term disability (box 7.1).

BOX 7.1

"We are just beginning to look at are we dealing with some autism or something else going on. Even if he is severely hearing impaired, I was just talking with the pediatrician yesterday, he should break out in a big grin when he at least sees me, even if he is not hearing me. He makes very little, very short eye contact. . . . So we are beginning to wonder about his capacity to respond that way."

Foster parents of these children become very attached to them as they nurse them through medical crises and rejoice at their survival and accomplishments.[3] Their input into planning is invaluable, as these children have unique needs. The grief they feel when the children leave is often not acknowledged, as is too often the case in all types of foster care (box 7.2).

BOX 7.2

The foster mother: *"Well, my major concern right now is the caseworker's determination to place him for adoption as soon as possible. And his attorney and my medical people and I all believe he is not ready. So I don't know. She keeps telling me she is not going to place him before he is ready, but she is recruiting families. I don't know how patient she will be. . . . By the time you have been through a lot of medical crises and you are not sure the kid is going to come out the other end and they have, you have a lot of attachment. I am trying to balance that out and make sure that it is not coloring my 'Oh, I don't want him to go for another year.' "*

Outcomes expected of medical foster care are similar to those of regular family foster care—safety, permanency, and well-being while in care. Many children do well and become strong enough that their biological parents, with training and community support, can assume their care. Permanency for children with severe medical issues or disabilities often means that devoted foster parents, who have nursed the child through many crises, become long-term caregivers. Long-term foster care can now be supported by guardianship if the foster parents think that they can manage with less agency support. Adoption is also an option: adoptive homes can be found, particularly if the children are young. Adoptive homes will require help in linking to appropriate services and probably a financial subsidy.[4]

Treatment Foster Care

Treatment foster homes (also called specialized foster homes or professional foster homes)[5] are homes that care for children with serious emotional and behavioral difficulties. Their development began in the 1970s, and there was extensive examination of this mode of care in the literature of the following two decades. This examination established that this was an effective and needed part of the continuum of care, and interest since 2000 has shifted to description of the mental health needs of children in these homes and the empirical validation of treatment models.

These are interesting homes, with special training and support needs. They receive high board rates for the difficult children they serve and have considerable responsibility for carrying out treatment plans. The foster parents' relationship to the child welfare system is usually different from that of regular foster parents, containing more elements of partnership with the agency.

Our understanding of treatment foster care is limited by the fact that many of the large data sets, including the Adoption and Foster Care Analysis and Reporting System (AFCARS), do not distinguish between regular foster care and treatment foster care. This is also true for many studies of children in foster care. Much of what we know comes from descriptions of homes that care for children with serious behavioral/emotional problems or with disabilities and from the literature on specific treatment modalities. National Survey of Child and Adolescent Well-Being (NSCAW) data on foster care identified relatively few children in treatment foster care, so it adds little to the overall picture, though noting its underuse (James et al. 2006). The Child Welfare League of America has a large multistate project under way, named the Odyssey Project, in an attempt to fill this information gap (Drais-Parillo 2004). As additional data are reported from that project, we will know more.

Characteristics of Youth Served There is very little demographic data specifically about the children in treatment foster care. The youngsters in treatment foster care seem demographically similar to older children in foster care. African American children are overrepresented. Data from the Odyssey Project provide the best picture available; the average age at entry to therapeutic foster care is 12, with a range from 5 to 20. Males (53 percent) slightly outnumber females. On average, youth had four prior living arrangements (Baker et al. 2007).

Most children come from impoverished families and have histories of abuse and neglect (Schneiderman et al. 1998). In the Odyssey study, abuse was prominent in the children's histories; 43 percent had been sexually abused and 43 percent physically abused. Substance dependency, criminal histories, and psychiatric disorders characterized the children's families or origin (Baker et al. 2007).

Children usually enter therapeutic foster care because of emotional and behavioral problems. These problems are generally serious and pervasive; the Child Behavior Checklist (Achenbach 1991), a widely used assessment tool, found scores in the clinical range for two thirds of the youth at admission (Baker et al. 2007). These data are similar to data reported from use of the Child Behavior Checklist with in a study of outcomes of treatment foster care youth in treatment foster care (Courtney and Zinn 2002) and are congruent with findings about intensive mental health placements from the NSCAW data (James et al. 2006). Eighty percent of the children in the Odyssey Project entered therapeutic foster care with a psychiatric diagnosis, 38 percent had a psychiatric hospitalization in their history, and a quarter had a history of suicidal ideation. Delinquent behavior had been exhibited by 38 percent, and a quarter had been suspended from school (Baker et al. 2007). Berrick found similar characteristics in a study of children in treatment foster homes in California (Berrick, Courtney, and Barth 1993). She also noted educational difficulties—about 30 percent of the children had repeated a grade in school; 40 percent were enrolled in some type of special education class.

In a qualitative study of children in treatment foster care, Dore (2001) noted traumatic histories of abuse and neglect and frequent changes of caregivers, followed by behavior problems that were extremely difficult for foster parents to manage. This often led to children being moved from foster home to foster home, and often into residential care for a time—a series of moves that, of course, exacerbated emotional and behavioral difficulties.

What distinguishes children in treatment foster care from children in regular foster care is the extent and form of their behavioral disturbance—behavior so difficult that the children cannot be maintained in regular foster care. And, as Dore (2001) noted in her examples of children's histories, the other thing that distinguishes them is the plain good fortune of having had a child welfare worker who recognized their need for treatment help and who was working in a system with the resources to provide it.

Treatment Interventions and Foster Parent Training Treatment foster care programs have developed from varied theoretical bases, and those origins are reflected in the training and interventions characteristic of each program. The common dimensions are the nurturing and supportive environments that foster homes are expected to provide, the close cooperation with professional staff, and the extensive training and professional support the foster parents can expect.

Foster parents are trained to use various treatment models, but not all models have demonstrated effectiveness. Multidimensional treatment foster care is an example of a treatment method that has been empirically validated and that has been successfully used in treatment foster care with a variety of troubled youth. It is also an example of the training and ongoing support that foster parents in treatment foster homes should receive. In this model, training and support are extensive: twenty-hour preservice training, continuing close support and supervision (daily telephone contacts, weekly support group meetings, and, in the early stages of a placement, weekly home visits). Program staff is available twenty-four hours all days of the week to provide support to foster parents. Parents are taught a supportive, behavior management approach to parenting that incorporates clear expectations, rewards for acceptable behavior, and penalties for infractions—emphasis is on positive support. Used with varied populations, it has produced positive outcomes for delinquent youth and youth with severe mental health and behavioral problems (Fisher and Chamberlain 2000).

Case studies are an excellent way of understanding the details of a service. A long and detailed illustration of treatment foster care is presented in a case study of work with an adolescent who had experienced significant early trauma with consequent reactive attachment disorder and was placed in a therapeutic foster home. The choice of a treatment modality based on the youth's capacities and difficulties is documented, and the course of his therapy is recorded. The foster parent training and the difficulties of parenting this young man are described, as is the slow progress and the limited goal of stabilizing the placement (Sheperis, Renfro-Michel, and Doggett 2003).

Psychotropic medications are a common part of the treatment regimen in therapeutic foster care and in residential care, and their extensive use in all of foster care has generated concern (Longhofer, Floersch, and Okpych 2011). The percentage of children found to be taking psychotropic medication varies among studies, with the percentage of those in treatment foster care being greater than that of those in regular foster care and less than that of those in residential care. Comparisons of children enrolled in Medicaid found psychotropic medication use could be up to three times as frequent among children in foster care, with a common finding that more than 40 percent of children in foster care were receiving these medications—with many receiving more than one medication (Solachany 2011).

Best practices mandate that medication be carefully prescribed in relation to a specific diagnosis and used in conjunction with other therapeutic interventions. For children in treatment foster care, these medications should be combined with other mental health services (Brenner et al. 2013). There is concern that medication may be being used to manage behavior rather than to help children control specific emotional or thought difficulties. Medication has proved useful in stabilizing behavior, but the long-term effects of use with young people are unknown.

The Experiences of Foster Parents Qualitative research detailing the experiences of the foster parent in interaction with caseworkers, other professional personnel, and the child's own parents has provided valuable insight into the context of specialized foster care. Though specialized foster parents identified many difficulties noted by regular foster parents, the impact was multiplied by the difficulties of their foster

children. The multiple roles they carry (advocacy for the child in schools, medical settings, and in the community; the strain of managing disruptive behavior and the need for constant monitoring; working with birth parents; and the demands of managing complex treatment schedules) are not different from regular foster care, but are much more complex and time intensive. Notably, even with enhanced payment schedules, these foster parents also said that caring for the children cost more than they were reimbursed (Brown and Rodger 2009). Foster parents lamented the absence of complete information about children coming into their homes, they noted their need for support and guidance as they dealt with difficult children, and they talked of the grief they felt when children left their homes. Inconsistencies in the definition of roles emerged; they saw themselves both in a parent role and in a provider role, and they received mixed messages from the professionals guiding the programs (Wells and D'Angelo 1994).

Interaction with the child's biological parents emerges as a major theme. Jivanjee (1999) concludes that "relationships and practices with parents were shaped by professionals' values regarding family involvement and their attitudes toward specific parents, and by TFC [treatment foster care] providers' willingness to communicate with parents and facilitate parent-child contact" (p. 333). All professionals and most foster parents expressed favorable attitudes about family involvement in foster care. If the foster parents think that the child's family members are "trying," foster parents will encourage contact, create opportunities for parents to interact with children, and work with child and parent toward reunion (Wells and D'Angelo 1994; Jivanjee 1999). Negative attitudes toward children's families seem related to foster parents' past experiences and are expressed as dislike or fear. Because the attitudes of providers influence the amount of contact, these attitudes can present a significant barrier to family involvement (Jivanjee 1999).

A foster mother in our study, who has had many children in her foster home, expressed her frustration with biological parents who do not do what she believes is necessary (see box 7.3). Note that she has had considerable interaction with parents and has permitted visitation at her home. She seems to be setting some limits here. Her attitude presents some contrast to that of the foster parent that was followed in the preceding chapter.

BOX 7.3

"I get so frustrated seeing moms come in at eleven months and they have had eleven months to get into drug treatment and clean up their lives. Two weeks before the court hearing they go into drug treatment, and 'Now I am going to get my life squared away.' And so they put the kid on hold for another year. Not okay.

"I've had several kids where I have had lots of visitation here at my house. I am not real excited about doing that. I am no longer willing to do that at the outset of a placement."

Another foster parent sees the importance of visits and works to facilitate them, as she describes in box 7.4.

BOX 7.4

"I said, it really won't hurt you to see your mom. No matter what your mother had done, she is going to love you forever . . . she is still learning. She still loves you . . . and he said, 'Okay, if I go and see her will you go, too?' I said, 'I will go on the visit with you.' 'Will you stay there?' 'If you want me to, I will stay right there with you.' "

Perspectives of Parents of the Children Emphasis in the literature is on the treatment foster home and the child. Though one would assume that the value of contact with parents would be similar to that of children in regular foster care, it is unclear how parental contact is implemented in the treatment foster care models.

The exception is multidimensional treatment foster care, in which the biological parent takes part in the planning of the intervention and participates in its implementation (Fisher and Chamberlain 2000).

The voice of the parents is heard in Jivanjee's (1999) study of parent perspectives about treatment foster care. The author conducted a qualitative study of ten families who were involved in their children's lives although the children were in placement. The families were typical of those described in larger, quantitative studies—struggling with the stresses of poverty, mental illness, and substance abuse, as well as having children with serious emotional or behavioral disorders. The attitudes of professionals, and to a lesser degree those of foster parents, were known to the parents and emerged as either barriers or facilitators of contact with children. Time spent by professionals in getting to know them, involving them in planning for their children, and assisting them with arrangements for contact with their children was deeply appreciated by these families, as was the sharing of information by foster parents. More convenient scheduling of visits and assistance with transportation to visits were noted as concrete ways that professionals could help facilitate family involvement.

The following lament by a biological parent illustrates the need that parents have to be kept informed about the welfare of their children (see box 7.5). It also raises questions about whether the agency has a right to use visitation as a "carrot" to get a parent to comply with a treatment plan. Given the importance of visits to child development and to reunification plans, is it good policy to restrict visits? Are visits a service or a right?

BOX 7.5

The mother: *"So what if I don't get to see him at this present time because I am not in [substance abuse] treatment? That still don't give you the right to deprive me of at least keeping me up on what's going on. Because the more you keep a parent away from what's going on with a child, the more you have them constantly thinking, 'What is going on?' It kind of sends them into a lot of chaos, a lot of stress."*

Outcomes Outcome research on treatment foster care has focused on discharge status, placement stability, program completion, and rates of movement into institutional care (Dore and Mullin 2006). In a review of outcome research on treatment foster care, Reddy and Pfeiffer (1997) reviewed forty studies and reported that treatment foster care increased the stability of placements for children and that it had positive effects in improving social skills and reducing behavior problems, though they noted the limited number of studies and lack of methodological rigor. Research suggests that treatment foster care may be effective in stabilizing children's behavior and may reduce placement in institutional care (Dore and Mullen 2006). Farmer et al. (2003) examined the role of treatment foster care in a continuum of care and found that while most placements immediately after foster care were into a less restrictive environment, the results "may be fleeting." By the time of a six-month follow-up, many had moved to group homes. These mixed findings will be clarified as more long-term follow-up studies are completed.

An exception to the lack of outcome research is the extensive and continuing inquiry into outcomes of multidimensional treatment foster care, which has been identified as one of ten evidence-based National Model Programs by the Office of Juvenile Justice and Delinquency Prevention. Originally developed and assessed in work with delinquent boys (Fisher and Chamberlain 2000), a twelve-month study of chronically delinquent girls showed that they also improved in major areas of functioning associated with delinquency and mental health (Rhoades et al. 2013). An adaptation for young children has been demonstrated to be effective in preventing behavior problems, increasing the stability of placements, and increasing positive

(return home) outcomes for young children (Price et al. 2008). For adolescents with serious behavior problems, it has been shown to be an effective alternative to more restrictive residential care placements.

The foster homes in the Casey Family Program lie on a continuum between regular family foster care, done the way it should be, and treatment foster care. Increasingly, they select very troubled youth for this foster care program, and increasingly it looks like treatment foster care. Fanshel, Finch, and Grundy (1990) found only about a fifth of 585 youths from a Casey Family Program follow-up study returning home or in a permanent placement, but one of the criteria of admission to the program was that return home was unlikely. Almost 60 percent were emancipated from the program, an outcome considered positive, as it meant the youth was not a runaway, in a psychiatric hospital, or in a correctional facility. Twenty years later, another follow-up study (Pecora et al. 2010) found a similar mix of outcomes, and again approximately 60 percent met the investigator's criteria for a successful placement (p. 229). These criteria involved positive functioning in domains of mental health and physical health, education, employment and finances, and relationships and social supports. Young people reported positive feelings for foster parents and that they had access to needed services. Both of these large studies, then, suggest that high-quality foster care, coming after disruptive early experiences, can be of considerable help to older children. Both suggest that for these youth, permanency planning was not a priority.

Testa and Rolock (1999) address the question of the role of treatment foster care in the child welfare system and make the point that treatment foster homes are expected to meet the criteria of all foster homes: (1) community-based care, (2) maintaining family integrity through keeping sibling groups together, (3) continuity of care in the same foster home, (4) caring for children in the least restrictive setting, and (5) moving children toward permanent homes. Comparing treatment foster homes with regular foster homes and with kinship foster homes, they found that kinship foster homes and treatment foster homes performed better than regular foster homes according to these criteria.

Because treatment foster homes work with very disturbed young people, most of who have been unable to live successfully in their own families or in regular foster care, many outcome studies are designed to compare their outcomes with those of youngsters in residential care. The common finding is that treatment foster care "is less expensive, offers comparable behavioral improvements, and offers a less restrictive treatment setting" (Reddy and Pfeiffer 1997:581). Studies that have compared multidimensional treatment foster care with group care find that it costs about half as much and is as effective as group care at changing behavior and maintaining youth in a community setting (Fisher and Chamberlain 2000). However, in this area also there are mixed results; one study of Boys Town youth, comparing treatment foster care and group care when both were using a teaching-family model, found that group care produced more positive outcomes (Lee and Thompson 2008). Research on other models of treatment foster care has not been as extensive, and models of group care are often not specified. Differences in child characteristics, lack of clarity in program models, and uncertainty about how treatment models are actually applied in the field have made data on the behavioral or social effects of treatment foster care less clear (Dore and Mullin 2006).

Finally, there are descriptive studies that report on positive behavioral changes shown by children in the programs. For example, Hazel (1981) reports positive change on a variety of social and psychological measures for adolescents in the Kent Project.[6] Similarly, Fanshel's longitudinal study of the Casey Family Program and Pecora's follow-up study both note positive behavioral changes, although the results confirmed that the children who had more

adversarial experiences prior to placement and showed more distress at placement had the poorest outcomes (Fanshel, Finch, and Grundy 1990; Pecora et al. 2010).

One is eager to have the results of more rigorous studies of additional models of treatment foster care to add to our knowledge base. Though treatment foster care appears to be a promising approach to working with severely troubled children and youth, in a community setting, there is little knowledge of the match of specific difficulties to specific treatment modalities. The relative placement stability that has been found is an important dimension and an indicator of the promise that specialized foster care may have for troubled youth.

Group Care: Meeting a Range of Needs

When out-of-home care must be provided for a child, the current emphasis is on placement in foster care as the least restrictive placement setting, the one most supportive of child development, and the least costly. However, for some children and adolescents, group care has benefits when family life in the youngster's home community cannot meet his or her needs. The community's view of the relative merits of institutional care and foster care has varied over time, as reviewed at the beginning of chapter 6, and as each has its place in the continuum of services to meet the varied needs of children and youth, the debate will probably continue.

The first goal of all group care programs is to provide a safe place where youth can begin to learn positive adaptive patterns to environmental challenges and/or disabilities. Facilities or programs in which children will be for a period of weeks, months, or years should provide (1) continuity of developmentally appropriate care giving, with stable caregivers, (2) maintenance of stability of sibling groups, (3) provision of a structured and predictable environment, (4) maintenance of meaningful connection with family, and (5) continuity with community and culture (New York City AIDS Orphan Project, as reported in Whittaker 2006:226). Most group care settings are better at meeting some of these criteria than at meeting others; most try to meet them all.

The Variety of Group Care Settings

Group care for children consists of a number of types of services. Some are clearly crisis services; some might become substitute families for children. The Child Welfare League of America identifies seven group care settings within the child welfare system: (1) supervised independent living programs, (2) emergency shelter care, (3) community-based group homes, (4) short-term diagnostic reception centers, (5) residential treatment centers, (6) intensive residential treatment centers, and (7) detention and secure treatment (Child Welfare League of America 2004). The first two are discussed in chapter 9, the remainder in this chapter. The varied options form a continuum from open interaction with the community to isolated and restrictive settings.

Group homes, located in the community, sometimes using community schools and housing twelve or fewer children, are at one end of the continuum of restrictiveness. Somewhat more restrictive are campus-based facilities, consisting of a cluster of separate living units, each housing twenty or fewer children. The campus is usually self-contained, though it may use some community facilities. Less family-like are self-contained group care settings housing up to forty children, often in one building. These are usually therapeutic environments that provide a high level of child supervision. Finally, secure facilities have the features of self-contained settings but maintain intensive supervision and may be locked facilities.

Residential treatment centers were developed for the most seriously compromised of the children with mental health or developmental difficulties. The definition of "residential treatment centers" varies; here the term refers to 24-hour care that includes on-site mental health treatment outside of a hospital. Residential care

encompasses a continuum of restrictiveness, ranging from locked facilities that provide intensive treatment, through more open facilities that encourage interaction with the community through special projects or trips as children are ready, to facilities from which some children attend community schools. Many facilities specialize to provide services targeted to particular populations, such as pregnant and parenting teens or teens with substance abuse problems.

Many residential care facilities are part of the mental health system or developmental disabilities system, though their history lies within child welfare, and they are part of child welfare's continuum of care. Pecora, Whittaker, and colleagues suggest that the events in the development of residential care in the child welfare system cluster in four stages: (1) a period in which the goal was to extricate children from the almshouse and provide separate institutions for them; (2) a move, in the late nineteenth century, from large institutions to large, family-style "cottages" staffed by house parents; (3) a "psychological phase" in the mid-twentieth century, during which the therapeutic milieu and group dynamics were considered important; and (4) a time of increasing attention to work with families and community supports (Pecora et al. 1992:404).

Although treatment efforts may be based on differing theoretical orientations, a common thread is the development of a "holding environment," in which the quality of the youth's life in the treatment milieu is the focus of intervention. Attention is paid to relationships with staff members and other residents, and the child's day is programmed in such a way that his or her therapeutic needs can be met (O'Malley 1993). Increasingly, residential treatment centers are turning toward behavioral interventions that are evidence based and are placing emphasis on maintaining relationships with family and community.

Multiple group care settings outside the child welfare system exist for troubled teenagers.[7] The outdoor programs, also called wilderness therapy programs and outdoor behavioral health programs, have received much publicity, both positive and negative. They offer highly structured, intensive, fairly short-term therapy in a wilderness setting. The wilderness setting is important, as it removes teens from their usual patterns of living, allows teens to experience the "natural consequences" of their actions, and builds self-confidence as they master new skills (Reamer and Siegel 2008). The wilderness program is often followed by a longer time in a boarding school that offers mental health counseling in addition to education.

Boarding schools have been used for generations, sometimes selected for the outstanding education they offer, sometimes selected with the hope that difficult behaviors will be remedied in the setting. Three types of boarding schools are available for teens struggling to adapt to their communities: boarding schools for teens with learning disabilities, emotional growth boarding schools, and therapeutic boarding schools. The first two of these look quite like traditional boarding schools, with the addition of counseling services and group treatment or peer-support groups. The students in these schools look much like those in public alternative high schools.

Therapeutic boarding schools provide "more intensive around-the-clock mental health care . . . [they] focus more on students' mental health, substance abuse, and behavioral needs while also providing a college preparatory education" (Reamer and Siegel 2008:35). Students in these schools usually have a diagnosable mental health problem and consequent behaviors that can have serious consequences. The description of their programs is much like a description of residential care programs, except that there is greater emphasis on college preparatory education.

A wide variety of systems are thus involved in the group care of children. The most intensive therapeutic settings are often under the auspices of the mental health system; the outdoor

programs are run by nonprofit or for-profit organizations. Any residential setting that cares for children who are developmentally delayed will have to follow the guidelines of the developmental disability services system for the care of children. Residential settings that house delinquents are usually part of the criminal justice system. And those that market themselves as schools are part of the educational system. Each type of institution must also cooperate with other systems to provide the specialized help that children need.

Numbers and Trends

The most recent census of all types of group care facilities for children and youth was conducted in 1981, and the authors of that study compare their findings with those of a 1966 census. During the fifteen-year interval, the total number of residential facilities increased, but as smaller group facilities became more common, the number of children in residential care declined. Only in juvenile corrections did large numbers of children remain in big facilities. Overall, the average length of stay decreased, facilities reported a higher proportion of children attending school in the community, and involvement with families was a component of the program for more facilities. The authors point out that these changes reflect the ability of residential care programs to respond to the increasingly complex situations of the children they serve; the changes also attest to the programs' recognition of the importance of family and community (Young, Dore, and Pappenfort 1989). Though the numbers are outdated, the trends are the beginning of a continuing direction.

The use of group care for children in the child welfare system continues to decline. In 2000, more than 100,000 children in the child welfare system were placed in group care. The 2012 AFCARS data show that 6 percent of the children in out-of-home care are in group homes and 9 percent in institutions—58,000 children and youth (U.S. Department of Health and Human Services 2012a). Data on the age of children in congregate care are not available nationally; data from New York show that congregate care is used primarily for older children, with a third of the children over age 14 in the child welfare system in congregate care settings. The same New York data show that between the ages of 14 and 17, institutional care is used for more than a quarter of these youth (Freundlich 2003).

Group Care or Family Care?

In the United States, young children needing out-of-home care are routinely placed with foster families, an approach that seemed settled by the weight of evidence concerning the damage that group care can do to young children. However, debate about the possibility of using institutions for care of young children emerged in the context of the welfare reform movement of 1990. If aid to children living at home was to be reduced, what would the fate of the children be? Prominent conservatives proposed return to orphanages as a means of caring for these children in a healthy, controlled environment. A series of newspaper articles about maltreatment in foster care added impetus to this movement. London (1999) provides interesting detail about the debate. The vision of reviving the orphanage did not survive public scrutiny, especially after the cost was better understood. But the debate had value in demanding the rethinking of the values of family care and group care.

Institutional care is used for dependent children in other parts of the world. It is more widely used in Western Europe than in the United States, and it is the primary mode of care for dependent children in less developed countries. Societal attitudes toward institutional care are varied. In Great Britain, for example, there has been a concerted movement to move children from institutions to foster homes, and by the end of the twentieth century very few children remained in institutions. In Germany, where parents' rights remain an unusually strong value, institutional care has

been more accepted because parents preferred it. In less developed countries, where nonrelative family care is not the tradition, institutions are common, and they are generally considered acceptable because they provide food and shelter for children. Many international child welfare agencies are striving to develop family care for young children, building foster care systems, and encouraging adoption.

Interesting data come from a follow-up study directed toward demonstrating good results from good care. McKenzie (1999) conducted a mailed survey of four thousand alumni of nine institutions that cared for dependent children who did not have special needs. He had a 50 percent response rate to this survey, which is quite good for that method of inquiry. The author acknowledges the impossibility of knowing about the nonrespondents. All respondents were white and, at the time of the survey, 45 years of age or older. Comparisons with census data indicate that in education, employment, and income, the orphanage alumni did better than the general population. Notably, however, they had higher divorce rates. Seventy-six percent of the respondents gave a "very favorable" rating to their orphanage experience. The positive attributes of the orphanage experience cited most often were personal values and direction (60 percent) and a sense of self-worth (59 percent). The most common negative attributes were separation from families and siblings (34 percent) and lack of love and emotional support from institutional staff (31 percent).

The feelings of others who have lived in group care are reported in varied literature. Fox and Berrick (2007) reviewed studies that had asked children's perspectives on care. One consistent finding was that children felt less safe in group care than in foster care. Another was that the quality of relationships influence their perceptions. On dimensions of well-being beyond safety, the authors did not note differences between children in foster care and those in group care. Data from NSCAW interviews with older children found them generally satisfied with their out-of-home care, but those in group care were much more likely to say they did not like the people with whom they were living (NSCAW 2003).

Bush (1980) conducted a set of interviews providing more depth of description; children actually residing in various forms of out-of-home care were asked for their evaluation of the experience. The children did not like living in institutions, finding them to be the least supportive of the forms of care. They felt that they were pretty much on their own and had to figure out how to manage with rules, staff, and other children. The fact that other children were always arriving and leaving was disturbing.

> At home, people don't just walk out of your life and you don't see them again. You always have some kind of connection with the person. They'll stick by you. But here maybe about ten people have come and left since I've been here. Maybe five of them were super close. (Bush 1980:250)

Children noted that "while staff had a set of rules to organize the institution, the children followed their own rules, which were different" (Bush 1980:250). Group homes were slightly better liked; children said they felt less lonely in them and fought less, but the difference was not large. The study is thirty years old now, but one imagines that the children's statements might still be descriptive.

Thus, for children whose major need is care and not intensive therapeutic intervention, it appears that group care is problematic. The expressed need for supportive adults, who relate to the child as an individual, is appropriate for the developmental tasks of that age and difficult (or nearly impossible) to provide in institutions. McKenzie's follow-up, however, demonstrates that well-staffed institutions can provide an adequate base for a productive adult life.

Group Homes

Group homes are defined as homes with twelve or fewer residents, situated within

the community, supervised and staffed on a 24-hour basis, and offering residents the full use of community resources, such as health care, education, and recreational opportunities (Child Welfare League of America 2004). There are two principal types of group homes. One type is staffed by child care workers, sometimes rotating as institutional personnel do, sometimes supplementing and giving relief time to a couple who are the parent figures in the home. In a second category are group foster homes, which are licensed for several children. Foster parents are the major caretakers, present as regular foster parents are. Beyond these basic parameters, it grows difficult to describe group homes as a whole—they range from regular foster homes licensed for six to twelve children to highly structured therapeutic settings with well-trained foster parents or staff.

Group placements are particularly appropriate for adolescents who are at a developmental stage where they thrive in a group culture. An adolescent moving toward independence, whose prior experiences make him or her unable to sustain the demands of a family, may need to live in a group setting that provides consistency and safety while fostering the development of the skills necessary for independence. They can, however, be useful for any child who cannot tolerate the intense parent-child relationships of a more traditional foster home.

Group homes are established in the community, usually in a large house or apartment. Children placed in them must be capable of maintaining reasonable social relationships with the neighbors and of attending public school. Interactions with schools, police, parents of the children placed there, and neighbors are frequent. One problem for foster parents is maintaining good relationships with the neighborhood, particularly if there are several active adolescents in the home.

Residential Treatment

Residential treatment placements meet the needs of the most seriously disturbed children in the child welfare system. They are designed so that therapeutic interventions can be woven into the structure of the child's day, and thus can be constant and intensive. As a placement that is relatively isolated from the community, residential care is not favored by those invested in the philosophy of developing a system of care for children that will serve them close to their families, and it is costly. The overall policy shift in child welfare and mental health services toward family preservation and community-based care means that the children who do come into residential care are more difficult and at greater risk than in prior years.

Characteristics of Children Wells and Whittington (1993) studied the characteristics of children admitted to one residential care facility in considerable depth. They found that the youths tended to come from impoverished families. In many families, the parents had separated, and most children had no contact with the absent parent. African American youth are overrepresented. Youths displayed "diverse, severe, and diffuse behavioral problems and significant deficits in their social competencies" (p. 213). Problems had emerged at an early age, and 93 percent had prior out-of-home placements. Bullard and Johnson (2005) review a number of studies that identify similar characteristics, and James et al. (2006), describing a sample of 254 youth from the NSCAW, also identify these characteristics. Notable is the seriousness of the difficulties that the children bring. In The Odyssey Project, describing the youth in residential care, 82 percent of youth were on some form of psychotropic medication at entry, and 29 percent were on antipsychotic medication. More than 40 percent had histories of criminal activity, and 40 percent had histories of prior psychiatric hospitalizations. One third had histories of substance abuse and suicidal ideation. Nearly 20 percent had histories of sexual perpetration (Baker et al. 2007).

In box 7.6, an example drawn from the interviews of Oregon families experiencing child

welfare services (the study that has provided other case examples in this book) illustrates the complex problems presented.

BOX 7.6

When John was 7, a psychiatrist told his mother that he was homicidal and needed care in a locked facility. His behavior has continued to be frightening to his family. The family lives in a poor community; John has been involved in thefts and drugs. He is now 13, and it has been difficult to find a placement that could meet his needs. For the past six months, he has been in a secure residential care facility three hundred miles from his home.

John's mother: *"It is scary. . . . Because he has hallucinations. . . . He was hearing voices tell him, 'Go ahead. You can jump over this fence [a fence topped with razor wire] and it won't hurt you.' He still has them. [The residential care facility] seems to think his psychotic episodes aren't as severe because he is not talking about them. He learned that if he didn't talk about them, and this is what he told me, 'If I don't talk about them, then people won't think that they are bad.' . . . I mean, when he comes home, I don't want him to have voices tell him to kill . . . his sister or somebody else."*

Numbers There are far more children in family foster care than in residential care; the latter is an expensive option for a small group of children who need intensive therapeutic services. Children and adolescents enter residential care from the mental health system (for example, after a stay at an acute-care psychiatric hospital), from the child welfare system (after other foster home or group home placements or after parents have asked for help), from the juvenile justice system, from the educational system, or through referral by a primary physician. In many cases, these young people are simultaneously involved with several systems. Because residential care is so expensive, custody is often awarded to the child welfare system so that public funds will be available to pay for care. The 2012 AFCARS data show that 9 percent of the children and youth in out-of-home care are in institutions supervised by the child welfare system (U.S. Department of Health and Human Services 2012a).

Restrictive Care Residential care is often considered a last resort and used when it is extremely difficult to manage a child's behavior in a family or community setting. However, if careful assessment determines that residential care will be the most effective placement for an individual child, it becomes an appropriate first placement. Residential care use has declined in recent years as there has been increasing emphasis on keeping young people as close to family and community as possible. The movement from institution-based care to community-based, family-focused care has been spurred by a general emphasis on fiscal responsibility in the provision of social services, by the development of managed care, and by the findings of various pilot projects that have demonstrated the feasibility of providing intensive services in family and community settings.

In this light, residential care is sometimes promoted as a short-term option, to be used until the child's behavior is stabilized and he is moved back to the community. However, this use of residential care seems to be infrequent. NSCAW data show that only about a quarter of the children who enter residential care through the child welfare system have short stays (less than three months) and only about a third stayed less than nine months. Within the three-year period of the study, a third of youth spent between one to three years in residential care settings, a fifth of those in one setting (James, Zhang, and Landsverk 2012). In the past, placements in residential care of two or three years were common, partly because the psychodynamic models of treatment in use demanded extensive periods in treatment. The varied treatment models currently under development may shorten this time in care, but the extensive difficulties presented by the children admitted to

residential care suggest that long-term care will remain an important option.

Treatment Models and the Role of the Family James Whittaker, a major writer on residential care, ended a recent policy discussion with the admonition that we need to develop a system that "softens the differences and blurs the boundaries between in-home and out-of-home" care (Whittaker 2006:225). Many residential care programs are developing ways of more effectively engaging children's families. Involvement of family would make the length of stay in residential care a less important variable, at least from the treatment perspective (box 7.7).

BOX 7.7

John's mother: *"He didn't want to come home to see us, and he was very honest about that. He said he wanted to come back to the area where his friends are so he could hang out with his friends and do drugs that he likes to do and just be on his own. . . . He is 13. He will be 14 in December. So that's why I finally got it through my thick skull that he may not be able to come home. . . . I am still working toward that goal. I haven't given up the goal. But I am more realistic that I don't think he will be able to come home and actually be a functioning member of the family. It is finally sinking in."*

In recent years, the trend throughout the field of child welfare has been toward enhancing the role of family. This trend is paralleled in the area of residential treatment. Residential treatment centers have historically been notorious for excluding the family. In the residential program, the child is the focal point of service; in recent history, not only was therapy generally reserved entirely for the child, but also a separation from parents was often considered therapeutic. However, gradually it was recognized that children do go home to their families and that the child was best served if family ties were maintained and the family was prepared to further the child's progress on his return. The rapidly expanding Youth Villages model, which uses intensive casework service with children and family (and prefers never to remove the child from his or her home), is perhaps the residential treatment model of the future (Grossman, Ross, and Foster 2008).

Residential care providers are increasingly exploring empirically validated models of treatment. System of care models with their wraparound services have some success in preventing discharge to more restrictive modes of care (psychiatric hospitalization or incarceration in the juvenile justice system) and fit with the philosophy of involvement of family and community. Boys Town is reporting positive results with the Teaching Family Model (Bilchik 2005). Youth Villages uses the re-education of emotionally disturbed youth therapy model, with data showing that 80 percent of the children are in a less restrictive environment a year after discharge (Youth Villages 2013). Other behavior modification models are still in use, as are psychotherapeutic models of treatment; most of these have not been empirically validated.

Even though changes are occurring, theoretical and logistical impediments to the inclusion of family in residential treatment programs remain. Parents are sometimes viewed as part of the "problem," and providers may believe that parental involvement will exacerbate or interfere with treatment. This is particularly true when parents have been neglectful or abusive toward the child. A logistical problem arises when the residential treatment center is located many miles from the child's home. This is likely to happen if the child needs long-term and/or secure residential treatment; out-of-state placement is often necessary because there are so few residential treatment facilities. Technology, however, has improved access for some parents: most practitioners in residential treatment centers today are well acquainted with "phone therapy," and Skype is on the horizon. But distance is a difficulty (box 7.8).

BOX 7.8

John is in residential care about three hundred miles from home, in an area where public transportation is almost nonexistent.

John's mother: *"I try to talk to him at least once a week on the phone. . . . If they would at least meet me halfway on visits. Make it a little more flexible for our face-to-face counseling, do it on the weekends, because when I work, and my husband works full-time, that would be the time we could get over there. . . . Also we were supposed to be able to do it on the phone, just kind of talk on the phone. . . . They would call me at eleven. And they knew that my lunch hour was eleven-thirty. . . . I lost one of my recent jobs because I would have to leave my desk and go take these phone calls."*

Cost Length of stay in residential treatment centers is an issue not only because of emphasis on community-based services and family involvement but also because of cost. Residential treatment is the most expensive of child welfare placement options. Bradshaw, developing an argument in favor of group care, estimated the cost of care at a residential treatment center as $64,000 per year and demonstrated that as numbers in care declined, cost per child rose (Bradshaw, Wyant, and McKenzie 1999:270ff.). Though these exact costs are dated, the comparisons remain valid. Thus, the relatively small number of children and youths who need residential care consume a high proportion of any child welfare budget, and residential care accounts for about 25 percent of the children's mental health budget nationwide (Bilchik 2005).

Managed care has had a considerable impact on the policies and practices in residential care. A family's medical insurance is often tapped to pay for residential care, and most policies will pay only for relatively short stays. Thus, residential care programs have been under pressure to develop short-term interventions. When a longer stay is needed, the state often takes custody of the child, through the child welfare system, in order to pay for the care. This process is difficult for parents and tends to increase emotional distance between the child in placement and his family (box 7.9).

BOX 7.9

John's mother: *"The last time we talked [to the residential care facility] my son was on the run. I think a day or two after we talked, my husband and I went out and tracked him down and found him. . . . He was kicking and hitting and trying to bite, spitting on us. It was really bad. So we got him to the [hospital] triage center. They kept him for twenty-four hours. Then I went back to the child welfare agency and requested that I place him in their custody, because I couldn't afford to get him placed anywhere. They were talking about five hundred dollars a day to place him in a private hospital."*

Safety in Residential Care Residential care has a reputation of being less safe for children than family care. Data are sparse. Reported maltreatment incidence rates vary greatly. In 1992, Spencer and Knudsen analyzed data from the state of Indiana and found a rate of 12 percent; the authors note that this rate is higher than for any other type of out-of-home care and significantly higher than that found in earlier studies. Sexual abuse was the most commonly reported form of maltreatment in residential care. Importantly, the authors note that other residents were perpetrators in 70 percent of the residential instances of sexual abuse (Spencer and Knudsen 1992). Using a sample of data from thirteen states, Merkel-Holguin and Sobel (1993) estimated a maltreatment rate of 51 per 1,000 institutionalized children. Poertner, Busey, and Fluke (1999) report the lowest rate, a rate of 1.5 percent over a five-year period. Again, sexual abuse was the most commonly reported form of maltreatment. Barth (2002), reviewing studies in the United States and other countries, suggests that the rate of abuse in institutions is

no higher than that in other forms of out-of-home care. As is true with foster care, alumni report higher rates of maltreatment: 24 percent of those who responded to a mailed survey reported having been physically, emotionally, or sexually abused at some time during long stays in institutional care (McKenzie 1999). The National Child Abuse and Neglect Data System (NCANDS) data for 2010 indicate that the abuse rate for children in all forms of group care is 0.01 percent; again, the low count probably reflects the strict definition of founded maltreatment (U.S. Department of Health and Human Services 2012b).

There is even less information about residential programs outside the child welfare system such as outdoor programs. The U.S. Government Accountability Office reports that between 1990 and 2007, it found "thousands" of allegations of abuse or neglect, some of which resulted in death (U.S. Government Accountability Office 2007). Even in well-developed programs with national reputations, children experience abuse and neglect. (Freundlich, Morris, and Blair 2004). Together these numbers give only a vague idea of the incidence of abuse and neglect.

Youth in congregate care report not feeling safe as a result of peer-to-peer violence (Freundlich 2003). Spencer and Knudsen (1992) note that 70 percent of the abuse that they found was inflicted by residents on each other. Stealing of belongings is a pervasive problem (Freundlich 2003).

Oversight and Staffing As detailed in the data in the past section, group care has a mixed record of providing safety. Reports of abuse in institutional settings seem to be in large part due to residents' attacks on each other, which suggests lack of supervision and poor staff-to-child ratios. There have also been reports of serious neglect of health of participants in some private programs, particularly outdoor or wilderness programs, and of treatment philosophies and practices that put participants at risk (U.S. Government Accountability Office 2007).

A mix of systems support and license some of the programs—child welfare, mental health, developmental disability. Some private programs are independent of any of these systems, and there is little oversight. More regulation is needed. The issue is complicated by the diversity of the programs and by disagreement within the field about the need for regulation (Reamer and Siegel 2008).

Stability of caregivers is an issue in group care. Most programs are designed to be carried out by shifts of staff, which means there is no continuity throughout the day and night. Residential treatment programs are often understaffed and struggle with high staff turnover, thus compromising continuity of caregiving. Many of the treatment interventions of residential treatment require highly trained and well-qualified staff, but the caregiving staff may not have these skills and training.

Lauren Polvere interviewed a sample of youth who were graduates of restrictive mental health placements, and their comments about staff training, treatment models used, and having some voice in planning their own treatment give some insight into the way youth perceive these placements.

> I was in two different residential treatment facilities, but they had totally different results. It's not so much the placement itself, but the people who work there. You can have the greatest system, but if you have a bunch of people who are just arrogant, mean, who are just not good with youth or kids, it is really not going to work.
>
> [Another youth] And I didn't even know when I was getting out, but I knew how it worked from being in the hospital, you know, if you're good, they're like "Oh, she seems fine let's let her go." And I was like, I want to get the hell out of this place, and so I was really, really, really good. Which seemed to them like I was getting better. I was never put in therapy . . . I had nothing. I was put on medication. (Polvere 2011:327, 329)

Outcomes Residential care is the most restrictive and the most expensive of the out-of-home settings. The children and youth who enter have serious mental health problems, manifested in emotional and behavioral difficulties. Often, they come to residential treatment after a series of failed placements. They need to be safe, to find stability if not permanency, and to have the intensive treatment needed to promote their well-being. Use of expensive and restrictive care, for this very needy group of children, demands that it be demonstrated to be better than alternative forms of care. However, evidence of the effectiveness of residential treatment is weak (Burns, Hoagwood, and Mrazek 1999; Barth 2002; Pecora et al. 2009; Lee et al. 2011).

Much evaluation of group care consists in tracking whether the sample group has improved over time. Outcomes measured at the end of residential stays are multiple and depend on the treatment model, the youth being served, and the goals of the residential stay. There is considerable use of standardized measurements of such areas as interpersonal conflict, personal control, aggression, moral development, and problem solving. Improvement in academic achievement is another common measure. Behavioral measures such as institutional and school conduct are also used. Though improvement during time in care is certainly valued, the bigger questions are whether youth can be discharged to community settings and whether gains can be maintained.

Increasingly, the goal of residential care is to help adolescents resolve underlying issues and manage behaviors so that they can be discharged to families, preferably their own families. The Odyssey Project found that more than two thirds of the youth in the programs studied achieved their permanency goal and that 52 percent returned home, with treatment foster care and residential care having about the same percentages (Baker et al. 2007). Some programs, for example the Youth Villages programs, work intensively with families throughout a youth's stay in care in order to accomplish this end and report that 90 percent of discharges from residential care are to a less restrictive environment (Youth Villages 2013). Data from the NSCAW are less positive, indicating that 23.9 percent of youth were reunified with family at the end of residential care (James, Zhang, and Landsverk 2012).

Much of the outcome literature compares residential treatment to other forms of treatment for severely disturbed youth and generally finds that outcomes for treatment foster care are as good as or better than those for residential care (Baker et al. 2007; Barth et al. 2007; James 2011; Lee et al. 2011; Preyde et al. 2011), as are outcomes for intensive home-based services (Barth et al. 2007). This body of research has led to questions about use of residential care. However, given the severity of the problems children and youth present as they enter group care, and their need for the intensity of supervision it provides, it fills a need in the continuum of care. Barth (2002) notes that it is particularly helpful for youth who may harm themselves or others and for youth who run away, placing themselves at risk and out of reach of remedial help.

Critical Issue: Long-Term Outcomes of Out-of-Home Care

Though data on the responses of children to various forms of care can yield valuable information about the shaping of that mode of care, we are also interested in whether these various forms of substitute care have provided our youth with the resources they will need to lead satisfying and productive adult lives. In the past few years, we have gained a good deal of new knowledge about how these young people "turn out" and about the conditions of their time in care that are associated with better outcomes. Adult functioning is the ultimate outcome of out-of-home care—though, of course, multiple variables in addition to out-of-home care affect these adult outcomes.

VanTheis (1924) was the first to study the adult outcomes of youth who had grown up in

foster care. She used the outcome variable of managing life in a "capable" way. Interviewing 235 adults twelve to eighteen years after placement, she found 88 percent to be "capable" and 12 percent "incapable." Many of these must have been long-term fairly stable placements, for an interesting aspect of this study was that it did not distinguish between foster homes and adoptive homes.

Between 1960 and 1990, there were several studies focused on the question of how children cared for in the child welfare system "turned out" as adults. For example, Maas (1963) studied the adult adjustment of children evacuated from London during World War II and cared for in nurseries (Maas 1969). Fanshel and Shinn (1978) followed children for five years through their foster care experience, and Fanshel, Finch, and Grundy (1990) tracked the experiences of children through foster care and into young adult years. Triseliotis (1980) focused on the impact of long-term stable foster care and later on comparisons of adoption and residential care (Triseliotis and Russel 1984). Festinger (1983) and Zimmerman (1982) considered the adult functioning of former foster children. Much data for these studies were obtained through interviews with adults.

These studies formed the basis for a comprehensive review of outcome studies of out-of-home care (McDonald et al. 1996). Outcomes studied were adult self-sufficiency, behavioral adjustment, family and social support, and sense of well-being.[8] McDonald concluded that though most former foster children were employed and had established a place to live, educational deficits translated into less secure and consistent employment. It appeared that there was no strong link between the experience of out-of-home care and adult antisocial behavior. About a third of the adults in these studies had married or established a stable partnership. More than three quarters were in touch with some member of their biological family. Thus, overall, most seemed to be doing reasonably well, to be capable.

Around the time of the publication of McDonald's review, reports began of the high proportion of former foster children among the homeless youth found on the streets of major cities and of the high proportion of adopted and foster children being treated for mental health concerns. Then studies using large data sets emerged, in particular from the Chapin Hall Center for Children in Chicago, the Midwest Evaluation of the Adult Functioning of Former Foster Children (Courtney et al. 2010),[9] tracing the transition out of foster care for youth in three state systems, and from the Casey Family Program publications of the results of the Northwest Foster Care Alumni Study, a longitudinal follow-up study of children who had been in the foster care system in Oregon and Washington, some in state foster care and some in the Casey foster care program (Pecora et al. 2010). Suddenly, we knew a great deal more about the outcomes of foster care and about those factors associated with better outcomes. This brief discussion of outcomes will focus in particular on McDonald's review and on these two large studies.[10] Data from smaller studies of alumni from institutional settings will be added when available. Finally, we will look briefly at two studies tracing the life course of foster children, tracking experiences (including institutional care) before and during foster care and relating them to outcome (Fansel, Finch, and Grundy 1990; Pecora et al. 2010).

There are several limitations to the data available. There is very little information on children with severe disabilities: they were excluded from the samples of most studies, and probably have greater challenges than most foster children (Greenen et al. 2007). We do not have distinct conditions to study: some children in foster care had also had residential care placements, and most children in residential care had also had foster care placements. Some of the foster care placements were in therapeutic foster care, others were not. Definitions of the groups being discussed are fuzzy at the edges—when does well-supported foster care begin to

resemble therapeutic foster care or an institution organized around cottages and focused on community involvement become more like foster care? Children entered and exited placements at differing ages. Placements were of varying lengths due to differing circumstances. The conditions of the termination of placements varied also. Thus, we are able to paint only a very broad picture of the well-being of young adults who spent significant time while growing up in out-of-home care.

The anecdotal reports of former foster youth on the streets or in the juvenile justice system are focused on youth in late adolescence and very early twenties. Independent living services (discussed in chapter 9) have been developed to assist these youth. The more interesting outcomes are those of young adults some years past discharge from foster care who have had time to establish themselves in adult roles.

Self-Sufficiency Self-sufficiency begins with adequate education to compete in the job market, and here those in foster care are at a disadvantage and those in institutional care at even greater disadvantage. While in foster care, a high proportion of foster children do poorly in school—quite probably as a result of the disruptions of their lives, difficulties in establishing attachments, and anxiety. A few years beyond foster care, about a quarter of the young adults had neither a high school diploma or a GED (Courtney et al. 2010), though by age 25 or older, 90 percent had a high school education, about the same percentage as in the general population (Pecora et al. 2010). Only a small proportion, 2 to 5 percent (Festinger 1983; Pecora et al. 2010), graduate from college.

These educational difficulties translate into low-paying unskilled or semi-skilled jobs in young adult years. In a careful analysis of employment data, comparing it with census data for the same geographic area and year, McDonald et al. (1996) show that, though the majority of graduates are employed, the employment rates are lower than those of the comparison groups. This finding is replicated in most studies of adults who have been in out-of-home care; about 70 percent of the participants in the Northwest study were employed, as were 52 percent of alumni in the Midwest study. Reflecting educational deficits, employment tended to be in low-wage jobs.

The various earlier studies find about a quarter of those who had been in out-of-home care receiving public assistance (McDonald et al. 1996); reforms in welfare (or improvements in care) have lowered this percentage to 16 percent in 2010 (Pecora et al. 2010). However, asked if they were receiving any kind of government benefits, three quarters of young women (including 89 percent of custodial mothers) and 29 percent of young men replied affirmatively (Courtney et al. 2010).

The follow-up studies show that most foster children have established independent living and have an adequate place to live. Meier (1965), whose 69 subjects were aged 28 to 32, found that two thirds of the men were married and had homes; all of the women, whether married or not, had established independent homes. The Midwest study, with younger respondents, found 40 percent to have established their own homes (and, interestingly, 21 percent living with their parents or biological relatives). Studies of homeless populations, however, find a high proportion of former foster children among the homeless, and Pecora et al. (2010) report that about a fifth of the Northwest study participants were homeless at least one night during their first year out of foster care. Several explanations are offered; among them that former foster children lack the family support networks that provide crisis assistance.

Antisocial Behavior Data linking out-of-home care and adult antisocial behavior present mixed results. McDonald and colleagues (1996) report that the behavioral indicators of the various studies suggest that arrest rates are higher than for the general population but may not be when controlled for race and socioeconomic

status. Courtney and colleagues (2010) present a more pessimistic picture of a high level of involvement of young men in the criminal justice system. On this variable alone, contact with the family of origin has been found to be associated with negative behavior (Zimmerman 1982). Self-reports of drinking and use of illegal drugs presents a mixed picture, with some evidence that use of drugs is greater among those who have been in foster care (McDonald et al. 1996; Pecora et al. 2010).

Establishing Families Adults who have been in foster care seem, in general, to be able to form social support networks that are satisfying. About a third have married or established a stable partnership. When adults were in their late twenties or early thirties when interviewed, a higher proportion had married, but the rate of separation or divorce was higher than in the general population (Meier 1965). At this age, Pecora et al. found almost two thirds of the Northwest study participants were married or in a committed relationship—somewhat lower than the national average for the age group—and most reported that they were satisfied with the relationship (Pecora et al. 2010).

Most disturbing is the difficulty that may attend parenting. Though Festinger (1983) reports that most children are living with their mothers, "a few" having used foster care temporarily, Meier (1965), working with an older sample, finds a fifth of the mothers to have had children in care. Pecora et al. (2010) found that 8.2 percent of alumni had children in foster care at some time during the ten-year period of the follow-up.[11] In contrast, nearly all of the mothers in the Midwest study had their children living with them, though more than 60 percent of the fathers reported that one or more of their children was living somewhere else (Courtney et al. 2010). In a study of adults who had been in residential care, the presence of a supportive spouse or partner was associated with good parenting (Quinton, Rutter, and Liddle 1986, as reported in McDonald et al. 1996). It is not clear whether this is also true for those who have been in foster care. A fifth of those who had been in foster care reported doubts about their ability to meet the needs of their own children (Zimmerman 1982).

Foster children return to their former families for support. Many find their biological families and reunite with extended families as adults. A third to a half are in touch with a biological parent and at least half with some member of the biological extended family (Pecora et al. 2010). Courtney et al. (2010) found 21 percent living with a biological parent or relative. And more than three quarters of those who had graduated from a foster care placement continued to be in touch with the foster family, finding in this family a source of support (McDonald et al. 1996).

Well-Being On a final dimension of personal well-being, assessed through measures of physical health, mental health, and satisfaction with life, the research is not conclusive. Individuals who have been in care seem more prone to mental health difficulties, but whether this is due to the separations and adaptations required in care or to the experiences that preceded care is, of course, unknown. Fanshel, Finch and Grundy's (1990) work in tracing the impact of events through the life course of a child and youth would suggest that both are important and that outcomes of foster care have to be viewed through the lens of pre–foster care experience.

Given the earlier discussion of disproportionate representation of children of color in the child welfare system (chapter 2), and given general knowledge about the disadvantage many persons of color find in our society, it is reasonable to ask whether the outcomes of foster care were worse for young people of color. The outcome studies are amazingly silent on this question. Three quarters of the participants in the Midwest study were non-white, predominantly African American, and three quarters of the participants in the Northwest study were white; there are differences in outcome, but

whether this is due to race or whether it is due to geography or differing times since discharge from foster care cannot be determined. Fanshel, Finch, and Grundy (1990) report on the different experiences of young people of color (about a quarter of the sample), and the differences for this sample do not reflect more adverse experiences. They were likely to have fewer difficulties early in foster care, experienced more continuity of care, and adapted well to foster care. At follow-up, they showed less evidence of emotional disturbance but were apt to be more socially isolated and have fewer supports.

Facilitating Positive Outcomes

In an analysis of those factors associated with better outcomes, McDonald et al. (1996) isolated the following dimensions. Children in foster care fared better than those in group care. Admission to care for neglect, abandonment, or physical abuse, was associated with negative outcomes; either these children had greater needs to begin with or foster care was less able to meet their needs. Fewer placements while in care were, as expected, associated with better adult functioning. Surprisingly, a longer time in care, if the placement was stable, was also associated with better outcome. Contact with the original family while in care resulted in greater identification with that family, but this identification was not uniformly associated with positive outcomes. Identification with the foster family tended to be associated with positive outcome.

Foster Care Noting the negative outcomes of foster care, those working with the Northwest foster care data asked whether foster care could be improved. Were there elements in the foster care program that were linked to better outcomes? A complex simulation of the foster care experience determined that if youth had an optimal foster care experience, overall outcomes would have been more positive. Reducing placement changes, providing access to educational supports, and developing life skills before youth exit foster care were the three aspects of foster care most strongly associated with better outcomes. Placement stability had a large positive effect on adult mental health and on educational achievement. The authors hypothesize that mental health difficulties played a role in educational difficulties and note that access to therapeutic supports is linked to positive adult outcomes. When these optimal conditions were introduced, "dramatic reductions in the estimated levels of undesirable outcomes were observed" (Pecora et al. 2010:216). Thus, it appears that foster care could be delivered in a way that would produce more positive adult outcomes.

The puzzling question is why outcomes of foster care are so disappointing. The children have received care at least as good as, and hopefully better than, they were receiving in their original homes. They have had access to various educational and therapeutic services. The outcomes of these experiences are discouraging to those working in child welfare, and better outcomes are elusive.

The experiences of the children prior to placement and the trauma of placement itself are doubtless part of the puzzle. In this regard, the work of Fanshel, Finch, and Grundy (1990) in tracing the life course of children in foster care deserves more space in the literature than it has received. The authors, through use of records and follow-up interviews, tracked the events in the lives of 585 children. Older, with different statistical analyses than are now used, it nevertheless presents startling findings that suggest a reinterpretation of some of the data on outcomes of foster care:

- Traumatic events—physical abuse before entry into care or severe physical punishment while in care and large numbers of living arrangements (including many changes of caretaker before entry into care)—have an impact into adulthood.
- Physical abuse has predictive power, particularly for boys. A strong chain of associations starting with physical abuse of a boy prior to foster care is associated with greater likelihood of physical punishment

while in foster care and with poor school performance and delinquency while in school, escalating into criminal offenses as an adult.

- A high number of living arrangements before entry was associated with more hostility and negativity at entry, which was associated with poor adaptation to foster care. The resulting large number of placements was associated with less favorable condition at exit—the youth not having been able to be sustained in foster care, but returned to family or discharged to the criminal justice system. Runaways (very few) were also unfavorable exits. Exit status predicted adult success.[12]
- Events occur in a chain of continuity, with later events summarizing prior events. Thus, the authors note, investment in therapy or group care that improves a child's condition will bear returns from that point on.

Current directions in child welfare seem to be responsive to these findings. The recognition of the impact of trauma on child development, the emergence of trauma-informed treatment protocols, and the emphasis on continuity of care offer hope that more children and youth can heal. Certainly, the importance of assessment and the provision of remedial services is underlined by these findings. For children with special needs, treatment foster care and residential care both offer chances for this early investment in therapy that will bear long-term returns.

Residential Care McDonald, in his review of research, concluded that those who had been in foster care had generally better outcomes than those who had spent time in residential care. However, he noted that those in residential care had arrived more troubled and after more placement failures than those in foster care, so that poorer outcomes might be expected (McDonald et al. 1996). Bullard (2006) also notes that many children who go into residential care present different problems at intake, among them severe mental health problems and behavior such that they are not successful living with families, and that many studies comparing the two types of care fail to control for these differences.

As with foster care, some patterns of residential care are associated with better outcomes. There are emerging data suggesting that group care that incorporates the family into its treatment protocol may have better outcomes (Grossman, Ross, and Foster 2009). Lee and Thompson (2008) found a family-style group care program (Boys Town) to be superior to treatment foster care. A mix of foster care and group care was found to be associated with better outcomes for very disturbed children (Fanshel, Finch, and Grundy 1990). Wells (1991), in a follow-up study of youth one to three years after their discharge from residential treatment, found family support to be positively related to self-esteem, mastery of life tasks, and absence of psychopathology; many had gone on to foster care, and stability in a single home was related to absence of substance abuse and antisocial behavior.

Summary Thus, the outcome studies show that alumni of foster care and group care experience many and serious difficulties as they work to establish themselves in adult roles. These outcomes are discouraging for those working with children in out-of-home care. However, they must be viewed while remembering that most of these children have experienced abuse and neglect prior to placement; in chapter 3, the devastating and long-term effects of maltreatment were reviewed. Finch, and Grundy have traced the impact of these early experiences on foster care outcomes. It is an admirable goal, but it is probably not realistic to expect graduates of out-of-home care to experience successes comparable to those of youth that have not had adverse experiences.

Summarizing the outcomes of care, the factors associated with positive outcomes are those that theory, practice wisdom, and almost a century of research would lead us to expect. Placement stability has a particularly strong

impact on outcome. Educational support is vital. Preparation and some tangible help make it easier to start adult life. Foster family support helps those leaving institutional settings. Notably, continued contact with the biological family, taught as such an important factor in out-of-home care, is not emerging as a predictor of good outcomes—more inquiry is needed to help us understand this.

Despite their difficulties in getting established, some studies suggest that as adults, most of those who were in out-of-home care seem able to function as productive citizens and think of themselves as having a good quality of life. The initial transition from foster care, described in chapter 9, may be the most difficult part of adult life. Out-of-home care is currently a necessary part of the continuum of care for our children. We need to focus on making it the best possible care.

Conclusion

The continuum of types of out-of-home care reviewed in this chapter and the preceding two chapters displays the range of choices available to a caseworker making a placement and highlights the need for careful assessment and matching of the child's needs to the type of placement that can best meet them. Our discussion of out-of-home care has progressed across three chapters, as we discussed kinship foster care, regular foster care, therapeutic foster care, and residential care, the latter two clearly designed for children and youth with a mix of disabilities, mental health problems, and behavioral issues. It is time to put together what we know.

Placement stability emerges again and again in the research; it is associated with positive experiences in foster care and with positive adult outcomes. Kinship foster care is the most stable of the placement options we have considered. Also of note, youth in foster homes of any kind had fewer re-placements when they were receiving strong support services.

Lack of placement stability affects educational success, which later affects the ability of youth to obtain work that will provide a living wage. With chaotic lives behind them, children enter the child welfare system already behind in school. Why they never catch up is not clear, but continued lack of stability and concerns about their situations as foster children are good suspects.

Placement matched to their needs and effective treatment is a key to children's adult success. The mix of placement types reviewed suggests that there should be possibilities for finding a match for any child's needs. Treatment effectiveness is undergoing more intensive scrutiny now, as all settings begin to focus on empirically based treatment modalities. Despite the difficulties in developing strong research designs in settings where a randomized control group is not ethical, one would expect rapidly increasing knowledge about the effectiveness of various treatment approaches.

A child's attachment to his family is another enduring theme. Surprisingly, large percentages keep contact with biological families during placement and return to them as young adults. Visits from parents are critical supports for children in out-of-home placement. Of all the placement options, kinship foster care optimizes this connection. Despite acknowledgment of the importance of parents, our child welfare system does not work well with them. Caught in the idea of "rescuing" children, we mandate certain services for parents in an attempt to change their lifestyles, and then expect compliance. Basic social work practice principles and values are discarded. We forget that our mission is to keep families and children safe and together.

Finally, we need to be continually aware of the impact of events currently and into the future. Trauma will have a lasting impact. Good experiences in foster care, effective treatment, and positive relationships will also have lasting impact.

NOTES

1. Part of a letter from a foster parent, cited in Charles Loring Brace, *The Dangerous Classes of New York* (New York: Wynkoop and Hallenbeck, 1872), p. 231.
2. For a discussion of the categories of disability recognized under the Individuals with Disabilities Education Act (1975), the reader is referred to *Future of Children: Special Education for Students with Disabilities*, volume 6, number 1. The issue defines and explains disabilities, giving the reader a good overview of the range of difficulties children experience and their varied intensity.
3. This is documented in Meezan and Shireman (1985) working with the question of whether foster parents might adopt the children in their care. Though it is an older study, many of its findings continue to be relevant.
4. See chapter 8 for a discussion of adoption subsidies.
5. Although the use of terminology is not consistent, authors tend to distinguish among forms of treatment foster care being provided by foster families caring for children with emotional/behavioral problems. In specialized foster care, foster parents are provided training "to create a nurturing therapeutic environment" in their home; they carry out interventions designed by professionals (Reddy and Pfeiffer 1997:518). In treatment foster care, the foster parents are viewed as the primary change agents; they are trained and supported as they design and carry out interventions. Professional foster parents may follow either of these models and are distinguished by receiving a salary, usually between $15,000 and $25,000 (in addition to board payments), and being viewed as agency employees.
6. The Kent Project was an early treatment foster care project in Kent, England. Intervention structure was based on task-centered casework. Contracts outlining specific goals and tasks to reach those goals were developed for each youth. The time frame was a two-year commitment by parent and youth to the placement. Foster parents were paid a salary such that, if they cared for two children, the amount was equivalent to what a parent would have earned if working outside the home. The homes were successful in retaining very difficult adolescents.
7. Reamer and Siegel (2008) offer a thoughtful description of these programs, as well as discussion of the controversial nature of many.
8. This excellent review must be used with some care, for family foster home care, group homes, and residential care are all considered "foster care."
9. This is a longitudinal study, with publications about various phases. Chapter 9, on the transition from foster care to adult life, contains considerable additional detail about the findings of this study and the Pecora study.
10. There is more detail about these studies in chapter 9, in which independent living services that work to prepare youth for adult living are described. In chapter 9, the focus is on how these outcomes can be compensated for with additional services. In this chapter, the focus is on what can be learned about foster care and group care. There is some repetition of information.
11. The rate at which foster care alumni have had to place their children in out-of-home care is high. Nationally, about 1.1 percent of children are placed in foster care every year (Pecora et al. 2010:148).
12. The authors note that ten changes in living situation, before or during care, led to devastating consequences. The average number of changes in living situation prior to placement in this sample was 6.89 (Fanshel, Finch, and Grundy 1990:43).

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8

Adoption

For whither thou goest I will go; and where thou lodgest I will lodge: thy people shall be my people, and thy God my God.

—Ruth 1:16

Adoption is a legal procedure by which a permanent family is created for a child. Adoptive parents assume all the rights and responsibilities of natural parents. Although there are three parties to every adoption—the child, the birth parents, and the adoptive parents—adoption is child-centered, focused on meeting the needs of the child. At its best, it also meets the needs of adopting parents, who have wanted a child, and the needs of the original parents, who are relieved of responsibilities they were not in a position to assume. Reitz and Watson (1992:11) have defined adoption as

> A means of providing some children with security and meeting their developmental needs by legally transferring ongoing parental responsibilities from their birth parents to their adoptive parents; recognizing that in so doing we have created a new kinship network that forever links those two families together through the child, who is shared by both.

Adoption is different: the dynamics of an adoptive family revolve around this linkage.

Adoption is fairly common. Most of us know someone who is adopted, has adopted a child, has a relative who was adopted, or who planned adoption for a child. Adoption is widely accepted in the United States—a cultural belief in the power of individuals to create their own future makes bringing a child into a family, and giving him or her resources to create a good life, seem like a natural step. In some other countries heredity assumes more importance, and adoption is not looked on as favorably.

The Framework of Adoption

We are experiencing a public policy shift toward increasing adoptions and a renewed interest in such issues as:

- making adoption policy and practice fully child-centered;
- determining the circumstances under which it is both wise and justifiable to separate children permanently from their original families;
- finding adoptive families for children with special needs, particularly for older children, for some very emotionally damaged children, and for some children with very severe physical handicaps, and ensuring that those families that adopt them have the ongoing support they will need;
- resolving ethical, and policy dilemmas surrounding adoptive placements that form nontraditional families, such as placement with single parents, transracial placement (usually placement of children of color in white homes), placement of children in homes with gay or lesbian parents, and open adoptions (adoptions where birth parents and adoptive parents know each other and may have continuing contact);

- recognizing that needs for services do not end with adoption, developing more uniform and higher-quality post-placement support services, and discovering which of these services are effective;
- recognizing that the birth mother's needs for services also do not end with the decision to place a child for adoption. Post-placement support services may be needed to process grief and/or to support an open adoption; and
- recognizing that many birth parents and adopted children want to find each other as adults, and resolving legal obstacles to this search.

Some of these issues, particularly those regarding termination of parental rights, have been discussed in earlier chapters. This chapter focuses on the controversial issues of current adoption policy. A brief look at the history of adoption will help ground the reader in the basic philosophy and practice of adoption.

A Brief History of Adoption

The first recorded adoption in Western tradition was that of Moses. It was an adoption in which the child of a subjugated people was adopted by a member of the dominant class—a transcultural and possibly transracial adoption in which a single parent independently adopted an infant whose birth parent's identity was concealed. We are told that the motive of the adopting mother was compassion, and the motive of the birth parent was to find a home in which the life of her infant would be preserved. (From the birth mother's point of view, it was an open adoption; the birth mother volunteered to act as nurse to the infant.) Many of the policy issues we face today are reflected in that adoption.

Early Placements and Their Regulation Adoption in the United States began rather informally, as children placed in family homes for fostering remained and grew up in those homes. This occurred when children were placed from orphanages (McCausland 1976), and to an even greater extent among the children moved to distant, free foster homes (as in the orphan trains, described in chapter 6). If the placement worked, children came to be considered part of the family, and an informal adoption had taken place. If the adoption was legalized, it was done through a specific act of the state legislature; these adoptions became quite common during the nineteenth century (Witmer et al. 1963).

Adoption in the United States has always been regulated by the states. The first adoption statute, passed in Massachusetts in 1851, became the model for subsequent adoption legislation: it outlines what are still the basic provisions of adoption. According to Kadushin and Martin (1988:535) it provided for:

1. the written consent of the child's biological parent(s);
2. a joint petition by both the adoptive mother and father;
3. a decree by the judge, who had to be satisfied that the adoption was "fit and proper"; and
4. legal and complete severance of the relationship between child and biological parents.

Some modification has occurred through years of adoption practice. If parents will not consent to adoption and are not able to assume responsibility for care of the child, the court can terminate their rights, as we saw in earlier chapters. In open adoptions, though the legal relationship between child and biological parents is severed, a social relationship may remain. A judge still has to be satisfied that an adoption is "fit and proper," and thus we see the great variation among the states in permitting adoption by different race parents, single parents, and lesbian and gay parents.

A Family Just Like Any Other In the years between the two World Wars, infant adoptions gained increasing popularity. The development

of infant formulas made it possible for young infants to thrive in adoptive families. The openness and opportunity of a fluid American lifestyle, with the frontier not far in the past, contributed to the perception that environment was as important as heredity.

In the period between the World Wars, legislation regulating adoption was enacted in the remainder of the states, so that by 1929 all states had adoption legislation. An increasing number of regulations were developed to protect children through requiring investigations of adoptive homes and by establishing supervised trial periods in adoptive homes. Specialized adoption agencies were founded to handle adoptions. These agencies almost exclusively placed healthy white infants with white couples. Some agencies charged fees to adopting parents on a sliding scale based on income; others charged very large adoption fees.

During this time, the provision that adoptive records be "sealed" became common. In order to protect the child from the stigma of illegitimacy, the birth parent from public knowledge that she had surrendered a child for adoption, and the adopting parents from possible interference by the birth parent, the original birth record was sealed by the court and an amended birth certificate was issued. It read as though the child had been born to the adoptive parents. The effect of these laws was, of course, to present the adoptive family to the community as indistinguishable from a family formed through the birth of children.

After World War II, adoption became a recognized solution to the problem of infertility. This was an era of "the perfect baby for the perfect couple" (Triseliotis, Shireman, and Hundleby 1997:7). The adoptable child was an infant or toddler, white, in good health, and developing at an average or better pace. Infants, even if adoption was planned from the time of their birth, were kept in foster care for at least six months to be sure that they had no problems. And as adopting couples were guaranteed perfect infants, an attempt was also made to guarantee infants perfect parents. The requirements that a husband and wife had to meet grew increasingly restrictive; adopting couples had to have a marriage of some duration, be within a specific age range (usually between 25 and 45), have steady and adequate income, and have comfortable housing spacious enough to add a child. Children and families were matched for religion, ethnic background, educational background, and appearance. With this careful matching, a family was created that was assumed to be "just like any other family." Once the adoption was finalized, it was not expected that the family would need any special community services. These traditional infant adoptions still form the image that many people have of adoption. However, the adoption world continued to evolve.

The 1960s brought startling changes in adoption. Adoptive parents themselves provoked the first change, insisting that they wanted to parent their infants from the time of birth onward. In a cautious beginning, placements of infants directly from the hospital were carefully monitored, and indeed adoptive parents proved able to cope with any unexpected developmental problems. The opportunity to parent very young infants made the families even more "like any other family."

David Kirk's *Shared Fate* appeared in 1964, presenting a new framework for adoption in which the difference from other families was acknowledged and viewed as an asset to the family. Although *Shared Fate* is now recognized as a landmark book, Kirk's ideas were little noticed until the 1980s, when the struggles of adopted adults began to be publicized and new forms of adoption became prominent.

New Forms of Adoption By the mid-1970s, fewer infants were available for adoption. In part this was due to new and more effective contraceptive methods and the increasing availability of abortion. In part it was due to changing sexual mores and society's increasing acceptance of a single woman raising a child.

Traditional adoption agencies began to experience long waiting lists for white infants.

At about this same time, a series of studies (reviewed in chapter 6) documented that many children were growing up in foster care. Planning for permanent homes for these children became important. Early research demonstrated that it was possible to find adoptive homes for children with physical handicaps and for older children (for example, Hargrave, Shireman, and Connor 1975; Emlen et al. 1976; Unger, Dwarshusis, and Johnson 1977). These families, however, no longer looked like traditional adoptive families; they included single-parent families, families with older parents, families currently fostering a child, and families who could afford to take in an additional child only if provided an income subsidy. Cautiously, placements of children growing up in foster care began. Also lingering in hospital nurseries or in foster care were healthy African American infants. Transracial adoptions began in the late 1960s and early 1970s, as adoption agencies realized that there were many white families eager to adopt these children. It was an exciting time, as adoption became truly child-centered, and as adoption agencies reported success after success in placing children with special needs. The slogan was "No child is unadoptable."

Another result of the scarcity of white infants was the empowerment of unwed mothers who chose adoption for their unborn babies. Women now had a real choice, knowing that society would permit them either to raise their children or release them for adoption. "Social workers began to listen more carefully to birth mothers' requests to be included in the decision of who would parent their children" (Carp 1998:202).

As families who wanted to parent very young children sought adoptable infants, the protections that had been built through regulating adoptions began to be compromised. Independent adoptions (adoptions where the birth parents selected the adopting parents, usually with a doctor or lawyer as intermediary) were one route to obtaining an infant. Other families adopted from foreign countries, usually less developed countries with few child welfare or family support services, where large institutions housed many very young children. Gradually, states began to regulate both of these types of adoptions, mainly through insistence on a study of the adoptive home by a licensed agency.

All of this, of course, changed the very nature of adoption. No longer were adoptive families "just like any other family." Older children had memories of their own parents and of their experiences prior to adoption. Infants often arrived through open adoption arrangements, in which the birth family remained linked to the adoptive family. Transracially adopted children did not look like their parents. These adoptions presented complexities that were not part of common experience, and adoptive parents began to ask for continuing professional support.

Questioning Adoption In the past three decades, Americans have been increasingly interested in their origins, culture, and genealogy.[1] Along with that has come a celebration of the diverse cultures that make up the United States. The emphasis that Americans began to place on family heritage and "blood ties" had an impact on the way adoption was viewed, raising questions about whether the social and legal family created by adoption was really enough to meet a child's developmental needs. Some have argued that children actually need contact with their biological families to thrive. Publicity surrounding the attempts of adopted adults to find their birth parents reinforced that idea.

However, as research began to document the poor outcomes of long-term foster care (described in chapter 6), the federal stance strongly affirmed adoption, emphasizing the importance to children of a permanent home. The Adoption and Safe Families Act (ASFA) passed in 1997 pushes the child welfare system to work toward adoption as a solution for

children who cannot be quickly reunited with family. Responding to the large numbers of children spending long periods in foster care, President Clinton established "Adoption 2002," an initiative designed to double the number of children placed in permanent homes each year (U.S. Department of Health and Human Services 1997). As part of these federal initiatives, bonuses have been established for states that substantially increase the number of children who move from foster care to adoption each year. As was detailed in chapter 2, these efforts have resulted in an increasing number of children finding permanent homes by moving from foster care to adoption.

Data from a public opinion survey about adoption in the United States suggests general approval of this emphasis on adoption. Most respondents, 94 percent, had a favorable opinion of adoption. Adopted children were viewed no differently from children being raised by biological parents. However, significant minorities of respondents (more than a third) think that adopted children (particularly children adopted from foster care) are more likely than biological children to have emotional, behavioral, and school problems (Evan B. Donaldson Adoption Institute 2002a).

As we have seen with regard to many other aspects of child welfare policy, changes in the society are reflected in the development of adoption policy and practice. Thus, we can be sure that the evolution will continue.

The Paths to Adoption

Children and their adoptive parents may arrive at a plan of adoption through any one of three major paths (figure 8.1):

- Children in foster care, because of maltreatment or abandonment by birth parents, may be adopted if efforts to reunify them with their families fail. Public child welfare agencies oversee these adoptions. These children are usually beyond infancy and have had traumatic life experiences. These are about 37 percent of adoptions in the United States.
- Birth parents may initiate the adoption. Both birth and adoptive parents may work through an adoption agency, which will do a home study of the prospective adoptive parents, provide counseling for the birth parents, and link the two parties. Or birth parents may independently identify an adoptive resource for a child, usually

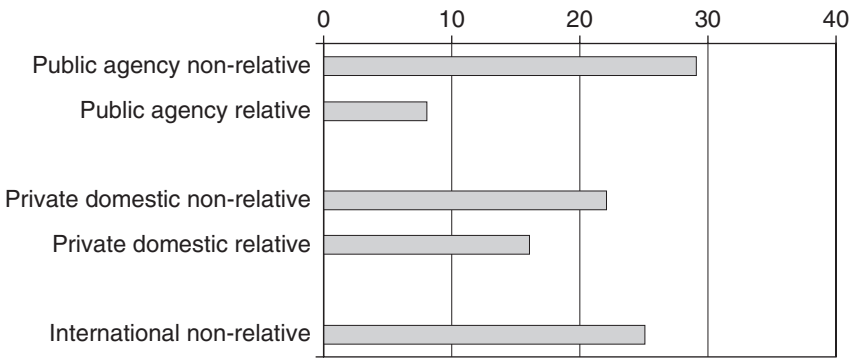

FIGURE 8.1. Percentage distribution of adopted children by path to adoption *Source:* National Survey of Adoptive Parents (2007) as reported in Vandivere, Malm, and Radel (2009)

working through a doctor or lawyer. Most of these adoptions are infants, often newborns. These private domestic adoptions constitute 38 percent of adoptions in the United States.

- Children are also adopted from other countries. These adoptions are governed by the laws of the country in which the children were born. After adoption, children must legally immigrate to the United States and subsequently be naturalized in order to become American citizens. The children in these adoptions are usually young but beyond infancy. International adoptions constitute a quarter of the adoptions in the United States (Vandivere, Malm, and Radel 2009).[2]

Adoption of Children From Public Agencies When the home of a child who has been abused or neglected cannot be made safe, adoption offers the opportunity for a permanent family. It is a vitally important part of public child welfare service. Adoption from foster care is a child-centered process, focused on finding homes for children. Usually, children are beyond infancy, and many of them have very special needs. There are usually no adoption fees in these adoptions, and adoption tax credits and government subsidies for children's care may substantially offset legal costs for the adoptive families.

It is time consuming to plan for these children, and while plans are being made, children wait in foster care. Legislative attempts to shorten the time spent in foster care have apparently had some impact. In 1990, the average time a child spent in foster care before moving to adoption was between 3.5 and 5.5 years (McKenzie 1993). Twenty years later, the mean (average) time in foster care before adoption was about two years (U.S. Department of Health and Human Services 2013).

The first part of this time is spent in extended work with birth parents to ascertain and support their ability to parent. As mandated by ASFA, concurrently with this work, there will be a search for an adoptive home, as well as discussion about adoption with the birth parents. If it is decided that a child cannot safely return home, and if the time allowed by ASFA (sometimes extended by the court) has run out, planning for adoption will begin. At this point, the parents may decide that adoption is the only available option and voluntarily surrender parental rights or the parents may go to court and contest the termination of their rights. The complexity of the legal process that leads to termination of parental rights (see chapters 2 and 3) extends the child's time in foster care; however, the legal procedure is vital for the protection of the rights of birth parents. If a new home has been selected for adoption, a final phase of the work is preparing a child for a move, making the move, and helping the child adjust to a new home.

Sixty-nine percent of the children adopted from foster care are adopted by the foster parent with whom they were living. Almost a quarter are adopted by relatives (some of who are also foster parents). Most (78 percent) of these families receive adoption subsidies—ongoing payments to adoptive families to help support the children or to meet children's special needs (Vandivere, Malm, and Radel 2009).

Private Domestic Adoptions Domestic adoptions accomplished through agencies and those negotiated directly between birth parents and adopting parents are both classified as private (not a state-supported agency) domestic (not international) adoptions. Many are adoptions of children related to the adopting family.

Private Agency Adoptions Private adoption agencies have a variety of origins and configurations. Some are long-established organizations, many founded by churches but now nondenominational. Some began as orphanages and have turned to the delivery of the services needed today. Some are religious agencies, firmly allied with a particular denomination

or religion. Some are relatively new and were developed to facilitate a particular kind of adoption, such as international adoption or open adoption. Some private agencies are large and offer a range of services including adoption. Some are smaller agencies, founded solely to provide adoption services.

The children and families served by voluntary agencies are as varied as the agencies. The common thread is that in an agency adoption, the child is surrendered to the agency, which takes responsibility for finding an appropriate adoptive home, placing the child in the home, and supervising the early months of the adoption. Some agencies also offer post-adoption support services. These agencies usually charge fees for their services.

Private adoption agencies have been important in the development of adoption services. Many have done groundbreaking work, pioneering adoptions that the big public agencies would not attempt, then evaluating and publicizing their work. Most of the new and sometimes controversial forms of adoption were first developed in the private sector.

Independent Adoption Independent adoptions are those in which the birth parents give their consent to the adoption directly to the adopting parents rather than to an adoption agency. The adopting parent(s) are advised by an adoption attorney, who handles legal documents and negotiates payments (usually for expenses during pregnancy) to the birth mother. Independent adoptions are legal in all but four states. Estimates are that half to two thirds of adoptions of white infants are independent adoptions (Evan B. Donaldson Adoption Institute 2002b; McDermott 2006). Although state laws mandate a home study prior to finalization of the adoption, the home study will not be extensive and will be to corroborate that the birth parents have chosen an adequate home. Independent adoptions are usually of infants; most have no special needs (Brooks, Allen, and Barth 2002). Although very limited, the research in existence suggests that most independent adoptions are satisfactory (Witmer et al. 1963; Meezan, Katz, and Russo 1978; Brooks, Allen, and Barth 2002).

Independent adoption offers little protection to the birth parents, even less to the child, and there are risks to the adopting parents. A doctor or attorney may not be experienced in helping families think through the implications of adoption, and the home study is often perfunctory and meant only to detect gross unsuitability. Birth parents receive little or no counseling as they think through their decision to plan adoption for the baby, setting the stage for unresolved grief and later regrets. They may also face pressure not to change their minds in the brief interval after the birth of the baby and prior to its going into the adoptive home. If either birth parent changes her or his mind about consenting to the adoption, the adopting parents will suffer emotionally and probably also financially, and if an infant is already in an adoptive home when the birth mother or father regret the decision, the situation is devastating for the adopting parents. Finally, should the baby be born handicapped in any way, the family may refuse to adopt the child, leaving the birth parents with a responsibility they are not prepared to handle.

International Adoptions About a quarter of the adopted children in the United States were adopted internationally (Vandivere, Malm, and Radel 2009). These adoptions began in 1956, as children left homeless in the aftermath of the Korean War were brought to the United States for adoption; it is a story reminiscent of the orphan trains of a century earlier (described in chapter 6).[3] International adoptions grew in numbers until 2004, when there were 22,990 international adoptions. The numbers since have gradually declined; in 2012 there were 8,668, about a third as many.

The decline occurred as questions began to arise about the conditions of consent to the adoptions on the part of birth families and

about the lack of resources within their own country for these families. Critics saw international adoptions as a method of finding children for parents, rather than finding parents for children who needed families. Sending countries were uncomfortable with not being able to care for their own children, and as scandals arose, some countries closed adoption opportunities. And adults who had been adopted internationally began to express their discomfort with their separation from their culture and race of origin.

Attempts to regulate international adoption through the Hague Adoption Convention (described in chapter 2), and thus to end some of the abuses, have been somewhat successful; at least, now most international adoptions are facilitated by a private adoption agency or licensed facilitator (Vandivere, Malm, and Radel 2009), thus affording children more protection. Whether protection has been afforded in greater degree to birth families is harder to ascertain. The details of these adoptions and the ethical questions they raise will be explored later in the chapter, as the various types of nontraditional adoptions are described.

Black-Market Adoptions Adoptions that involve the purchase of a child are illegal around the world. They involve payment for a child—either to an intermediary or directly to the child's parents—that is not for medical care, lodging during pregnancy, or legal services. "The community and professional consensus is that such efforts to obtain children by making outright payments compromise the mother's integrity and endanger the child's well-being (Pecora, Whittaker, and Maluccio 1992:376). Suspicion of this type of payment has been behind the decisions of several countries to refuse to send children to other countries for adoption.

The Cost of Adoption

The expenses of adoption vary with they type of adoption. The least expensive adoptions were adoptions of children from foster care; many had no expenses and almost all were less than $5,000. Adoptions of children by relatives (a quarter of the adoptions from foster care and more than a third of private domestic adoptions) were also less costly; 94 percent had expenses of less than $5,000 (Vandivere, Malm, and Radel 2009).

Other types of adoption are much more expensive. The average cost of adoption through a private agency is $20,000 to $45,000; program fees and attorney's fees are the largest part of the cost. Independent adoptions cost between $20,000 and $40,000 with birth mother expenses (contribution to her expenses during pregnancy) and attorney's fees being the largest portion. The expenses of international adoption vary by country; in 2014 they were between $20,000 and $40,000, with program fees and travel (including travel documents) the largest expenses (Building Your Family 2014).

A federal adoption tax credit was established in 1996 as part of legislation to increase adoptions. As of 2013, the maximum reimbursement amount was $12,979. Parents adopting from private agencies or internationally are most likely to use this tax credit. Some employers help with adoption costs; this happens most often with international adoptions (Vandivere, Malm, and Radel 2009). Despite this available help, the cost of adoption can be prohibitive and would be a concern for half of those responding to a National Adoption Attitudes Survey (Evan B. Donaldson Adoption Institute 2002a).

Numbers of Children Involved in Adoption

The reader will remember from chapter 2 that data on adoptions are not systematically tabulated by any single agency. Until 1975, adoption statistics were kept by the National Center for Social Statistics; since that time, there has been no federal attempt to develop adoption statistics. Adoptions from foster care are reported through the Adoption and Foster Care Analysis and Reporting System (AFCARS) system. Data on international adoption can be found in the immigration database of the U.S. State

Department. However, there is no way to count the number of adoptions through private agencies or the number of independent adoptions.

For fiscal year 2000–2001, Flango and Caskey (2005) used state court data and vital statistics records of the various states, as well as immigration data, and estimated that 127,000 children were adopted. They report that this number had remained relatively constant since 1987. The 2007 survey of adoptive parents used statistical methods to develop population estimates from their sample, arriving at an estimate of 1.8 million adopted children in the United States (Vandivere, Malm, and Radel 2009). The Census Bureau reports that in 2004, there were 2,528,000 adopted children in the United States; this figure includes adoptions by stepparents. With data so difficult to gather, the scholar will find discrepancies as various sources are compared. However, from this incomplete data, estimates can be made and trends noted.

Adoptions from foster care have increased steadily in recent years as a result of state projects and federal incentives. Twenty thousand children were adopted from the foster care system in 1996; by 2000, this number had increased 78 percent to 50,000, and by 2009 to 57,115. This was the peak year for adoptions from foster care; in 2012, the number was again 52,039 (U.S. Department of Health and Human Services 2013).

Historically, child welfare services have not been able to find sufficient same-race adoptive homes for children of color. Time spent waiting in foster care for adoption is of particular concern for these children. In 2012, 26 percent of the children in foster care waiting for adoption were African American, and 23 percent were Hispanic; 23 percent of the children adopted from foster care were African American, and 21 percent were Hispanic (U.S. Department of Health and Human Services 2013). Providing adoptive homes for these children will require creative and intensive home-finding efforts, willingness to consider nontraditional forms of adoption, and adherence to the tenets of the Multiethnic Placement Act (MEPA).

There has been a long-term trend toward adoption of older children. At one time, almost all adoptions were those of infants or very young children. By 2012, only 2 percent of the children adopted from public agency foster care were under 1 year of age; 46 percent were between 1 and 5 (U.S. Department of Health and Human Services 2013). Most adoptions of infants occur through private adoption agencies or internationally, and there are no data on the number adopted each year.

A National Adoption Attitudes Survey showed that while 73 percent of the respondents would be willing to consider adopting a child who had been in foster care for several years, medical and behavioral problems were of concern; only 47 percent would consider adopting a child with behavioral problems and 56 percent a child with medical problems (Evan B. Donaldson Adoption Institute 2002a). The prevalence of physical and mental health problems among foster children suggests that it may not be easy to find homes for these youngsters. However, it should be possible.

The importance of foster parents as an adoptive resource for the children in their care is underscored by recent AFCARS data. Of the children adopted from the public child welfare system in 2012, 53 percent were adopted by their foster parents, and 31 percent were adopted by relatives (U.S. Department of Health and Human Services 2013). The continuity of care achieved for these children is a great accomplishment of the child welfare system.

An Ethical Dilemma: Opening Sealed Records

At the time of adoption, original birth certificates are sealed, and the adopting family is issued a birth certificate that reads as though the child was born to this family. This allows the child to display a birth certificate for school, passport, driver's license, and so forth, without having to explain adoption. For many years,

birth mothers entered into confidential adoption arrangements and were promised that (1) the adoption records would be sealed by the court and (2) only those whom the birth mother told would ever know about the child released for adoption. Adoptive parents also felt protected in these confidential adoptions, thinking that the birth mother would not know the whereabouts of the child and could not interfere with the new family.

A growing number of adopted adults, often those who are hoping to locate birth parents, insist that they have a constitutionally based civil right to know the identity of their birth parents. This adoption rights movement has been active since the 1970s and has garnered extensive political and media attention.[4] Seven states have significantly expanded access of adopted adults to their birth records; in these states, there is a mechanism for birth mothers to file a form requesting no contact. A few other states allow access to the original birth certificate under certain conditions, mostly limiting access to more recent adoptions and to those in which there is no request by the birth parent for nondisclosure on file (Carp 2007; Howard, Smith, and Deoudes 2010; Child Welfare Information Gateway 2012).

As adopted adults have increasingly pressed to learn more about their biological heritage, and perhaps even to get to know their biological families, an ethical dilemma has arisen.[5] In the context of our current society, adoptees have a right to this knowledge. However, agencies made contracts with birth mothers in the context of that time, and to many those agreements may remain enormously important.

Twenty-eight states have dealt with the dilemma by establishing mutual consent registries, in which an adopted adult can indicate a wish to find a birth mother or a birth mother can indicate a wish to find an adopted child. If parent and child are matched in this way, there is no problem. But often there is no match. Twenty-four states also have "search and consent" statutes, which provide that a birth parent may be contacted by a "confidential intermediary" and, if the birth parent consents to disclosure of identity, the disclosure may be authorized by the court (Howard, Smith, and Deoudes 2010). Adoption agencies also have established registries in the hope of matching a searching person with a consenting person.

In fall 1986, the Child Welfare League, in its role as a leader in policy development, passed resolutions at its biennial conference recommending that "starting with children adopted in 1986, confidentiality shall no longer be in effect once the adopted child reaches eighteen or the age of majority," and that "agencies should advocate the development of state and provincial laws to allow adopted individuals who have reached the age of majority to be given all identifying information, with the consent of the birth parents, or after posting an appeal for their consent" (Watson and Strom 1986). The Evan B. Donaldson Adoption Institute has endorsed the opening of all birth records to any adult adoptee who asks. These policy documents state that a birth certificate is the right of the adoptees and vital to their sense of identity. They also state that very few birth mothers oppose the opening of birth certificates (Howard, Smith, and Deoudes 2010). And available data do suggest that most birth mothers welcome contact. In the first five states to use contact preference forms for birth mothers, less than 1 percent opted for no contact with adult adopted children (Howard, Smith, and Deoudes 2010). In Oregon and Tennessee, states that have opened their birth certificates to adopted adults, the courts have found that the guarantee of anonymity to birth mothers is not legally enforceable. And there have been no reports of ill effects in those states that have opened their records (Howard, Smith, and Deoudes 2010). Birth mothers have also been active members of organizations supporting the opening of birth certificates.

Two factors now lessen the relevance of the debate. Only a third of adoptions are now private domestic adoptions; many of these adoptions are

open adoptions in which identifying information has been exchanged. And increasing numbers of adoptions are of older children from foster care; these children know their birth names and history. In addition, the Internet, with its multiple search sites, has made it almost certain that those searching will find the information they seek, if they persist. This in itself suggests that closed adoptions are fast becoming obsolete. Nevertheless, the debate surrounding opening birth certificate records is intense, as it should be. The ethical dilemma is real.

Protecting the Adoption Triad

In adoption, as in all child welfare services, the primary focus is the welfare of the child. As we have seen, however, during some periods and in some types of adoption, the concerns of the adoptive parents have been preeminent. Most likely to be forgotten are the interests of the birth parents. But an adoption that is carefully accomplished in a way that protects the interests of each of the parties can be a very positive solution for all three parties.[6]

The Birth Parents

Though we acknowledge, intellectually, the benefit that adoption can bestow on a child, as a society we tend to be critical of birth parents that plan adoption for their children. Almost twenty years ago, a national survey found that "many Americans support birth parents' decisions to place children for adoption, but a substantial minority disapproves of decisions to do so, and some even see it as irresponsible or hard-hearted" (Evan B. Donaldson Adoption Institute 1997:1–2). One would hope that opinions had changed in the intervening years, but the attitude seems to persist. It is reflected in our language. Rather than saying that adoption was planned for a child, more often people say a child was "adopted out"—a more careless and exclusionary phrase.

Parents of Infants The rate at which women relinquish infants for adoption has declined dramatically (Evan B. Donaldson Adoption Institute 2006). The decline, of course, reflects changes in society; better contraception and the availability of abortion have decreased the number of unwanted pregnancies, and changing social norms have enabled more single women to keep and raise their children. As a result, many fewer white infants are available for adoption, and considerably more attention is paid to the needs and wishes of birth parents.

Mothers decide to relinquish their children for a variety of reasons. Often they are young and have not yet finished their education or established themselves sufficiently to support a family. Mothers that decide on adoption tend to be white, from intact families, and better educated than other birth mothers (Pierce 2006). Birth parents have told us for a long time that giving up a child was not an event from which one easily moved on with life (Wells 1993; Christian et al. 1997; Gritter 1997; Fessler 2006).

> The studies . . . tell us that some of the lasting feelings carried by birth parents who give up children for adoption include continued guilt and anger and feelings of loss and grief. . . . Some relinquishing mothers' sense of loss, far from diminishing with time, seems to intensify and is particularly high at certain of the child's milestones such as birthdays or starting school. (Triseliotis, Shireman, and Hundleby 1997:99–100)

In earlier years, the birth mother was the least powerful of the figures in the adoption triad, the most likely to be exploited, and the least likely to receive sensitive social work services; but the situation has changed. The shortage of infants available for adoption has given birth mothers who want to plan adoption for expected infants a great deal of power in the adoption triad.

One outcome of this shift in status has been the development of open adoptions, in which the birth mother has a voice in the selection of the adopting family and can negotiate with the adopting family concerning continued contact—these are discussed at greater length

later in this chapter. Another outcome has been increased recognition of the responsibility of social workers and other professionals who have contact with the mother to recognize her feelings and provide the support she needs as she makes her decision.

Not very much is known about the parents in other countries who surrender infants and young children for adoption, other than that they are very poor. Exploitation of birth mothers remains a danger; the safeguards of the Hague Adoption Convention are intended to provide protection. Nevertheless, lack of strict laws and practice guidelines for international adoptions, as for independent adoptions, has allowed children to be treated as a commodity by some "adoption facilitators."

Birth mothers tell us that relinquishing a child is deeply traumatic, and an event whose effects linger for a lifetime (Fessler 2006).[7] Open adoptions, when the birth mother can retain contact with the child and family, seem to provide a situation in which the birth mother finds a role for herself as a support to the child and family, and these feelings are more successfully resolved. (Siegel and Smith 2012; Grotevant et al. 2013).

So far our discussion has concerned birth mothers only, and indeed most of the extant literature is about birth mothers. Only a minority of infant adoptions involve fathers in the process. Birth fathers' rights have been protected as a result of the U.S. Supreme Court case *Stanley v. Illinois* in 1972: unwed fathers who have been involved in the care of their children have the right to participate in the adoption decision. However, the fact that the father is often left out of the adoption process can have unfortunate consequences. In a 2013 U.S. Supreme Court case (*Adoptive Couple v. Baby Girl*), a Native American father, citing Indian Child Welfare Act (ICWA), challenged the adoptive placement of his daughter, arranged by the mother, into a non–Native American home where she had lived for several months. A few of these situations are in the newspapers; there are probably many more.

Many states now have putative father registries; these are registries in which a man may register as a potential father to a child. He then will receive notifications about any action for adoption of the child. In registering, he admits paternity and assumes financial responsibility for the child. Failure to register will compromise any late intervention he may attempt.

Birth mothers (and fathers) may, when the children have become adult, want to find and get to know the children they released long ago. Aside from stories in the media about successful reunions, we have relatively little information about their motivations or experiences. When searches are successful, adopted adults generally report that the experience was positive—in this respect the data support current media representations (Haugaard, Schustack, and Dorman, 1998). Similarity of lifestyles, appearance, and values were associated with a closer relationship with the birth mother; relationships with birth siblings often became, over time, closer than the relationship with the birth mother (Muller, Gibbs, and Ariely 2003). Fessler (2006) contains in-depth stories told by birth mothers—some of these include reunions. Birth mothers search for their adopted children through the agency to which they released their baby, through state registries, and, increasingly, through the Internet. Reunions can be troubling experiences if the expectations of either party are not met. They can reawaken the trauma of the original separation. And, as the media have shown us, they can be positive and fulfilling for both the birth mother and the adopted adult.

Parents of Older Children We know even less about the reactions of families who release older children to adoption or whose parental rights are terminated by the courts. Most of these parents have abused or neglected their children, have later made attempts to create a home to which the children could return, and have been unable to do so. Some release children voluntarily when skilled social work or mediation helps them recognize that this is a

way they can plan responsibly for their children. Others release children voluntarily when they realize that adoption is the only available option, and that a voluntary agreement will help them retain some rights to contact with the child. Some fight bitterly to retain custody and lose the children in court. Once satisfactory plans have been implemented for the children, the case is closed in the child welfare system. There has been remarkably little interest in studying how these parents handle the loss of their children.

The Adopting Parents

Adopting parents, like foster parents, come in all shapes and sizes, with talents and circumstances as varied as those of the general population. Reflecting the traditional household, and the caution of those working in adoption, most adopted children (69 percent) live with two married parents. Parents who adopt internationally are most likely (95 percent) to have education beyond high school, and they have the highest incomes. Those who adopt children from foster care have the least education and lowest incomes. Thirty-eight percent of adopted children are the only children in the home. Adoptive parents are slightly more likely than all families to live in well-maintained and safe neighborhoods, and almost all (95 percent) live in neighborhoods with amenities such as parks, playgrounds, recreation centers, and libraries (Vandivere, Malm, and Radel 2009).

However, many adopting parents do not fit this rather traditional profile—some are older, some are gay or lesbian, some are single parents. In a third of the adoptive homes, both parents work full-time (and if a single parent, that parent works full-time). Adopting foster parents have the most complex households, with 40 percent of the households having three or more children, and 40 percent having both adopted and birth children. Those adopting from foster care are also the most likely to adopt sibling groups (Vandivere, Malm, and Radel 2009).

Though there are many adoptive applicants for every white infant, older children, children with special needs, children of color, and sibling groups are more difficult to place. In their efforts to find homes for these children, public agencies recruit adoptive parents. Recruitment takes many forms—most visible are newspaper stories and television spots about specific children who need adoptive homes. Adoption agencies also publish newsletters and hold adoption "fairs" where children and prospective families have a chance to interact. Some of these recruitment techniques are controversial because they involve specific children, but they are fairly successful in finding adoptive homes. One recruitment tool is the webpage of the Adopt America Network (www.adoptamerica.org).

Many of the practices and policies concerning the selection and preparation of foster parents (discussed in chapter 6) apply also to adoptive parents; in fact, in many places, those interested in long-term foster care and those interested in adoption go through the same processes. In contrast to earlier practices of selecting the "perfect family" (based on social workers' standards of family living), the preparation process is now considered to be collaborative. The agency prepares prospective parents for the available children while prospective adopters decide whether they have the capacity to undertake such challenges as behavior problems, disabilities, and/or continuing contact with the birth family.[8] The home study should take place prior to the placement of a child in the home, but this is not always possible when a relative or a foster parent is adopting a child or when a child has been placed independently. Once a child is in a home, the child's need for continuity of care makes it difficult to decide that the home is not suitable.

Families have different reasons for deciding to adopt. Enjoyment of children is a common denominator. Infertility is behind many adoptions; these families often want to have the full experience of raising a child and want to adopt as young an infant as possible. Adopting

parents often have altruistic motives, wanting to care for a child who needs a home. One of the tasks of recruitment and training is to help applicants recognize the complexity of adoption and that, though rich in rewards, it is not "just like having your own baby."

In the past, it was thought that no further services would be called for once an adoption was finalized. However, the voices of adopted adults have made us aware that all adoption is complicated. The adoption of older, more difficult children has made the need for post-adoption services even more evident. These children carry legacies of loss and trauma, and it may be difficult for adoptive parents to provide the necessary support and nurture and to establish a close relationship with them. The critical issue examined at the end of this chapter concerns the outcomes of adoption and the post-adoption services provided and needed.

The Children

Adopted children also come in all varieties. Traditionally, we think of adoption as involving healthy infants, but Vandivere, Malm, and Radel (2009) found that only 32 percent of adopted children were less than a month old when they entered their adoptive families. Increasingly, it is older children who have a history of difficult experiences that are being adopted. To get a sense of the ages, races, and personalities of children currently waiting for adoptive homes, visit the website of the Adopt America Network (www.adoptamerica.org).

Preparation Children who are beyond infancy need preparation for adoption. They need permission, time, and help to mourn the loss of their original families—to master this trauma. They need to understand the reasons for their removal from their original homes. If possible, they should have the opportunity to discuss the impending adoption with members of their own family, either to formally end the relationship or to plan continuing contacts.

It is helpful if a child and worker can together develop a "life-book"—a compilation of pictures, documents, and explanations that documents as much as is known of the child's past. This life-book goes with the child into adoption and helps create order from a fragmented past. Pre-adoptive preparation also offers the child the opportunity to explore the idea of a new family and his or her own wishes, desires, and possible fantasies. This direct work with children is time consuming and professionally challenging. It requires skilled supervision and is resource intensive. And it is not done as extensively as it should be; one study found that only a quarter of children had come to their adoptive homes with a life-book (Howard 2006).

Another source of protection for the child is the social worker's careful work in preparing the family for the particular characteristics of the child they adopt. Adopting families need to know everything that is known about the child, both discussed with them and provided as written information so that they can look back and remember what was discussed. This also is not done as well as might be expected; the study referenced above found that only 45 percent of the families had written background information. Families stress over and over that they need to know everything in order to parent the child appropriately (Howard 2006), and there is legal liability for withholding information.

Placement The final part of preparation for adoption is the actual move to the adoptive home. Participation in this can make the transition much less traumatic for the child. Older children need to be told about the prospective adoptive home and participate in evaluating whether it will meet their needs. Good practice stipulates that the child, whatever the age, and prospective parents will meet and have opportunity to become acquainted and then have a series of visits during which the child stays for progressively longer times in the home of the adopting parents. The move is gradual, the child learns that people do not disappear

suddenly from life, and child and family know each other well before the final commitment is made.

During the Adoption The primary purpose of services for the adoptive family after the placement of the child in the home is to support the family so that it will remain a permanent placement for the child and will continue to meet the child's needs. These services customarily are provided through fairly frequent contacts with the adoption worker in the months immediately after the placement. As the adoption approaches finalization, the adoption agency has a responsibility to see that the family knows about the range of post-adoption services available and can access them as needed. Adoption is truly a lifelong process.

Just as there was for a long time a dearth of information about the perceptions of foster children, so there is little about how children view adoption. Ideas that have made their way into the literature suggest that older children feel uneasiness around the process of adoption, particularly around separation and loss of biological parents.

Data from longitudinal studies following adopted children into adolescence are beginning to provide more detail. Children adopted as infants who have been told they are adopted begin to ask questions around the time they enter school; follow-up discussions of adoption are few, and children know less than parents think they do (Shireman 1988). Ryan and Nalavany (2004) found that children think that adoption carries some stigma. Most adopted youth are curious about the circumstances of their adoptions, and they want basic information about birth parents. At adolescence, the most common question becomes why they were placed for adoption; by young adult years, curiosity focuses on birth parents' health histories (Grotevant et al. 2013).

Adolescents who have grown up in adoptive homes are to be found in the literature—but again mostly scattered throughout and not with a focus on adoption itself. Transracially adopted young people have written about their perspectives on the experience, some expressing comfort with the adoption and some despair, but the focus is on the racial identity. Internationally adopted adolescents have made their voices heard, but the focus is on racial differences and cultural discontinuity, not on adoption itself. When children and youth were asked to compare adoption and foster care, they preferred adoption, valuing the lack of ambiguity about status in the family and the stability (Triseliotis 2002).

The Great Variety of Adoptions

As adoption has changed in recent years, the image of the perfect family for the perfect baby, resulting in a family just like any other, has been replaced by adoption that takes many different forms and results in many kinds of families. The healthy baby has been replaced by older children, children with physical and mental disabilities, and children with serious behavioral disturbances. The traditional family has been replaced by parents of all kinds, including single parents, gay and lesbian parents, and working-class parents who need subsidy to be able to afford the addition of a child to their homes. The "family just like any other" has been replaced by families with children and parents of different races, and from different countries, and by families that include the birth parents and extended family of the adopted child.

Controversy remains about many of these types of adoption. Each must be examined with consideration of the extent to which it affords the child the conditions for optimal growth and development, and then of the degree to which it protects the rights of the birth parents and the adopting parents.

Traditional Adoptions

Adoptions by a married man and woman of the same race as the adopted child, without disclosure of identifying information or provision for post-adoption contact between birth and adoptive family, are labeled traditional. They are the

type of adoption that composed the majority of adoptions for many years and are the picture that comes to mind for many people when they think about adoption. They are actually a very small percentage of adoptions currently.

Adoption of Healthy Infants There are relatively few healthy infants available for adoption today. Changes in society's attitude toward unmarried parenthood and the availability of birth control and abortion have greatly reduced the number of women who need to plan adoption for an expected baby. Most of those who do plan adoption want a nontraditional open adoption. Adopting families who want an infant and no contact with birth families tend to think about international adoption.

Infants and Young Children with Special Needs Early in the movement to find adoptive homes for "all children who could use a home," it became apparent that it was not going to be difficult to place infants with developmental delays or physical handicaps. Outcome studies of these placements are often twenty years old and are scarce, but generally suggest that families are content with the adoptions. Many are pleased that the children have exceeded their expectations.[9] More recently, placement of infants who had experienced prenatal drug exposure was of concern: because so little was known about their prognosis, many people were hesitant to adopt them. Rather surprisingly, in their adjustment eight years after adoption, "according to their adoptive parents, children who are prenatally exposed to drugs appear to function very much like other adopted children on educational attainment and emotional or behavioral adjustment" (Barth and Brooks 2000:46). Having established that adoptive families deal with disability much like any family, the adoption literature seems to have ceased to identify these children.

Older Children Kadushin's (1967) follow-up study of children older at adoption was groundbreaking, indicating that it was possible for children who had early experiences of abuse or neglect to function well in adoptive homes, and it opened the door to the idea that older children might succeed in adoption. Thus began the process of finding adoptive homes for the children who were in long-term foster care placements and the expansion of our ideas about how adoptive families are composed.

Foster Parent Adoption

Foster parent adoptions are commonplace now, but it was not until the 1970s that child welfare agencies began seriously to consider foster parents as an adoptive resource. At that time, there were large numbers of children identified as "drifting" in long-term foster care placements, and there was increasing concern about finding permanent homes for them. Kadushin's work demonstrated that adoption of older children was possible (Kadushin 1967), foster parents began to declare their interest in adoption (Hargrave, Shireman, and Connor 1975), and it was realized that this was a resource for children and a resource that would avoid a change in placement for them.

With almost two thirds of the children adopted from public child welfare agencies now being adopted by their foster parents, some of whom are relatives, it is apparent that foster parents are a major adoption resource. They are valued by child welfare agencies. Most (78 percent) receive an adoption subsidy, usually less than the board rate they were getting for the children, but enough that the transition to adoption can occur without financial strain. Two thirds also have a guarantee of health insurance coverage (Vandivere, Malm, and Radel 2009). The children they adopt are usually older, and perhaps because of the difficult start these children have had, 46 percent receive post-adoption rehabilitative services,[10] as do only one third of all of the adopted children. Children adopted from foster care were also more likely to receive tutoring (Vandivere, Malm, and Radel 2009).

Some foster parent adoptions are the result of fostering a "legal risk" child—a child that the social worker believes will need to be adopted, although parental rights have not yet been terminated. These are interesting families. They applied to foster rather than adopt, usually with the hope of receiving a young child that might later be available for adoption. There is little literature about them. They are willing to invest in a child in the hope it will be theirs, yet are expected to work with biological parents toward return of the child, as long as that is the plan. It is a fine plan for the child, who avoids a move, but a difficult role for the foster-adoptive parents.

Other foster parent adoptions are made by foster parents who have cared for a child for a number of years and, when that child becomes available for adoption, decide to adopt rather than have the child moved. Slightly more than half of the children these foster parents adopt have disabilities and/or serious emotional/behavioral problems (Meezan and Shireman 1985; Howard, Smith, and Ryan 2004). Nevertheless, these homes are likely to be successful adoptive homes, for the foster parents know the child well prior to adoption. The transition from foster home to adoptive home is not simple, however, and the child may test whether his or her new status really is permanent (Meezan and Shireman 1985).

As birth parents have been visiting in these homes when they were foster homes, the adoptions are mostly open adoptions. There is no information about how many have post-adoption contact with parents or other relatives or how these contacts affect the adoption.

Single-Parent Adoption

Adoptions by single parents are not as controversial today as they once were. In 1965, when single-parent placements began, adoption practice was heavily influenced by psychoanalytic theory, which postulated that both a mother and father figure were necessary for a child's intrapsychic development. The public has always been comfortable with single-parent adoptions, because this form of family has "worked" for children over the centuries. Gradually, professionals have become more certain that single parents are capable of providing good adoptive homes.

Characteristics The percentage of adoptions by a single parent has grown rapidly. In the 1970s they constituted about 2 percent of adoptions; today they are about a third of all adoptions. Of the single-parent adoptions, 5.5 percent are single fathers. The highest proportion of single parents (38 percent) is among private domestic adoptions (Vandivere, Malm, and Radel 2009).

One would hope that in the years since 1970, it would have become easier for single parents to adopt. Browsing the websites devoted to advice to single-parent adopters, it seems that the obstacles to adoption in the 1970s are still there and are particularly difficult for men to overcome. Often, agencies prefer two-parent homes and will consider single parents only for "hard to place" children, those who are older or have special needs (Groze and Rosenthal 1991; Shireman 2006). Birth mothers may prefer a two-parent family when they have a voice in selection, though this is not always the case. Single parents who want a young child sometimes turn to international adoption, though only certain countries will accept single parents.

Outcomes The evidence suggests that single parents manage the complexities of an adoptive family well. A longitudinal study, which followed adoptions of young children by single parents over sixteen years, noted these strengths: (1) commitment to the child and the adoption, creating a close and nurturing bond; (2) strength and capacity to handle crisis; (3) a relatively simple family structure, which meets the needs of some children; and (4) self-confidence, independence, and ability to develop and use supportive networks (Shireman and Johnson 1985). A study of the outcomes of adoptions of special-needs children found that the children adopted

by single parents have the lowest percentage of problems (Groze and Rosenthal 1991). Using the Children's Behavior Checklist scores (Achenbach 1991), a comparison of the development of girls adopted from China by single parents and by two-parent families found no substantial differences in adjustment among either preschool or school-age children, and found the adopted children to have better scores than the U.S. norms (XingTan 2004). The research is limited, but the outcomes are positive.

We need to know more about the capacities of single-parent adoptive homes. They have received little recent study, as attention has turned to newer forms of adoption. We do know that single-parent homes are not homes in which to place a child for whom no two-parent home can be found. They are homes with unique strengths. These are homes in which to place children whose background and experiences are such that they can benefit from those strengths.

Adoption by Gay and Lesbian Parents

For many years, adoptions of children by gay and lesbian parents were hidden in the statistics of single-parent adoptions. Those who wanted to adopt did so as single parents; if agencies knew they were placing children in gay or lesbian homes, it was easier to "look the other way." Gradually, as the struggle of gay and lesbian persons for their civil rights continued, and as it became clear that the children of these families did well, agencies became more open about acknowledging them and placing children for fostering and adoption with them. Still, few agencies actively recruit these families.

The extent of these adoptions is difficult to estimate. Working from census data, Mallon and Wornoff (2006) identify approximately 65,000 gay fathers and 96,000 lesbian mothers who are heads of households and have at least one child. There is no way of knowing the proportion of these families that were formed through adoption. We do know that the number of these adoptions is substantial and growing.

Barriers to Adoption Adoption agencies, responsive to community pressures, have been slow to adopt policies that openly permit these adoptions. A national survey by the Evan B. Donaldson Adoption Institute revealed that at least 60 percent of adoption agencies would accept applications from gay or lesbian single applicants or couples, with religious affiliation and perceptions that birth parents would not accept these adoptive homes being the chief obstacles. Ninety percent of public agencies accepted these applications, and over half of gay or lesbian applicants applied to the public child welfare system (Brodzinsky 2011).[11] Agency policies are in flux as state laws change and the era of "don't ask, don't tell" seems to be ending.

Workers implementing agency policy may also create barriers. They may hold biases emanating from family influence, cultural affiliation, or religion, biases that distort their evaluation of gay men and women as potential adoptive parents (Mallon 2000; Ryan, Pearlmutter, and Groza 2004). Reports from those who have adopted stress the importance of allowing adoptive applicants to be open and the importance of recognizing and discussing the issues that gay and lesbian adopters will face (Brown et al. 2009). Preparation for adoption and support early in the adoption have emerged as important factors in the success of the adoption (Averett, Nalavany, and Ryan 2009).

The acceptance of gay and lesbian adoptions varies geographically, and in some parts of the country adopting parents need to be prepared to face community disapproval. Laws in most states are silent on adoption by gay or lesbian persons. As recently as 2010, a statute in Florida prohibited adoption by gay persons, but this provision was ruled unconstitutional by the Florida Court of Appeals. Mississippi prohibits adoption by couples of the same gender, and Utah bars adoption by persons who are cohabiting but not legally married (Child Welfare Information Gateway 2012). Family court systems have demonstrated openness to adoption by gay and lesbian individuals and, to a lesser

extent, by couples, particularly in the northeastern United States and the Pacific Northwest (Matthews and Cramer 2006).

A joint adoption is obviously preferable. It gives both parents equal status, conferring on the child the protection of the surviving parent should one parent die, as well as securing social security, medical, and inheritance rights for the child. As a rapidly increasing number of states recognize marriage between same sex couples, and as additional states recognize civil unions, these legal barriers will change and adoption will become increasingly easy.

Outcomes The adoption of children by openly gay or lesbian parents is new enough that there is very little research on the skills of these parents in raising children or on the special issues they face. Flaks (1995), in a thorough review of research concerning gay and lesbian parenting, concludes that "to date, no evidence has emerged that suggests that homosexual parents are inferior to their heterosexual counterparts, or that their children are in any regard compromised" (p. 33). More recent reviews confirm this (Mallon 2000; Meezan and Rauch 2005).

Studies of gay and lesbian adoptive homes are even fewer. However, gay and lesbian parents have been adopting children for years as single parents, and follow-up studies of single-parent adoptions suggest that some of these very successful adoptions are actually lesbian and gay adoptions. A comparison of adoption outcomes for gay and lesbian couples and heterosexual adoption finds that differences in outcome for adolescents were associated with such factors as abuse prior to adoption, family functioning, and adoption preparation, but were not associated with sexual orientation of adoptive parents (Averett, Nalavany, and Ryan 2009). This finding seems to be echoed in less ambitious studies of various aspects of gay and lesbian adoption.

Policy Implications As adoption agencies remain in touch with their communities, there is in these adoptions an opportunity to gently push these communities toward acceptance of gay and lesbian families. Objections to these adoptions seem to be based both on lack of knowledge and fears about gay and lesbian households, and on moral convictions about the immorality of gay or lesbian unions. The work of gay and lesbian organizations as they strive for civil rights is doing a great deal to enhance knowledge and dispel fears. Given the positive outcomes that seem to be occurring, one must ask whether it is more immoral to place a child in a gay or lesbian adoptive home or to let the child grow up in foster care.

Domestic Transracial Adoption

Transracial adoption refers to the adoption of a child of one race by parents of another. It also is controversial and arouses strong passions. Concerned about social justice, many question whether it is morally acceptable for people of a dominant race to be responsible for the socialization of the children of oppressed races; with resulting loss to the original culture of its children. This is the issue behind the Indian Child Welfare Act, reviewed in chapter 2. Transracial adoption has a different vision, looking toward a society in which people of various races and cultures live and work together.

A History of Controversy When transracial adoption began in the 1960s, it was a "fit" with the civil rights movement and the spirit of a society moving toward racial integration. The pace of such adoptions was accelerated by the reduction in the number of white infants available for adoption, the increase in the number of African American children in the foster care system, and the new commitment to finding a permanent home for every child. From a cautious beginning in the 1960s, the number of transracial placements in the United States grew rapidly, until in 1971 there were 2,474 transracial placements (Triseliotis, Shireman, and Hundleby 1997:163).

In the 1970s, as the richness of minority cultures became more widely celebrated, the goal of many concerned with race relations became

cultural integrity rather than integration. In 1972, the Black Association of Social Workers issued a statement condemning transracial adoption. Adoption agencies, both public and private, almost universally ceased making transracial placements. By 1975 (the last year in which adoption statistics were systematically generated), the number was 831 (Bartholet 1991). Despite attempts to recruit ethnically diverse adoptive homes, the numbers of African American children in foster care continued to grow.

By 1994 there were almost 500,000 children in foster homes. Children were waiting a median of two years eight months to be adopted, and African American children waited longer than other children. In response, the MEPA was passed in 1994 and was amended and strengthened in 1996. The law prohibits the denial of a child's adoption because of race, color, or national origin.[12] It was expected that removing the barrier child-placing agencies had erected would open more homes to African American children and increase the numbers adopted from foster care. This hope was enhanced by the vocal support of advocacy groups composed of potential adoptive parents (mostly white) who were interested in transracial adoption.

MEPA has apparently had limited effect. There has been a slight increase in the number of African American children transracially adopted from foster care. There has been confusion about which practices are permissible and which forbidden under the law. Additionally, categorical assumptions about the benefit of same-race placements have been part of the policy, written or unwritten, of child-placing agencies for the past twenty years. Changing practice is dependent on legislation, policy, and on practitioners embracing the change.

Transracial adoptions are about a quarter of domestic adoptions and 40 percent of all adoptions. (figure 8.2). Our best data estimates that 28 percent of the children adopted from the foster care system and 21 percent of private domestic adoptions are transracial—about a quarter of domestic adoptions. Most international adoptions are transracial (Vandivere, Malm, and Radel 2009).

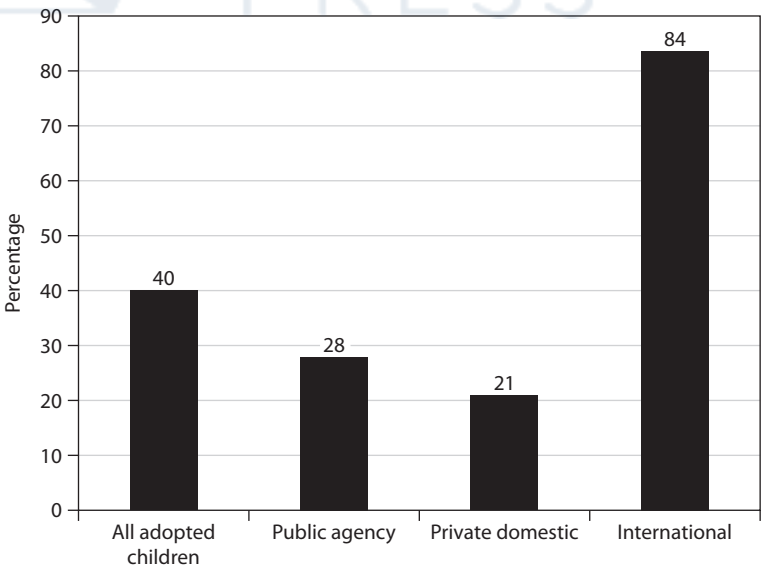

FIGURE 8.2. Transracially adopted children by path to adoption *Source:* National Survey of Adoptive Parents (2007) as reported in Vandivere, Malm, and Radel (2009:14)

Outcomes Because of the controversy surrounding them, transracial adoptions have been subjected to extensive research.[13] The findings of the studies are broadly similar. Repeatedly, they find that about 20 to 25 percent of the transracially adopted children experience moderate to severe problems in family, school, or community. This is about the same percentage found in same-race adoptions. Transracially adopted children appear similar to other adopted children on measures of self-esteem. In spite of the fact that many have been raised in predominantly white communities, measures of racial identity elicit pride in their racial heritage. Factors that facilitate managing the racial difference well include supportive parents, open communication in the family, and living in a multiracial community, so that there is opportunity to interact with children and adults of one's own race. Young adult findings mirror those of childhood.

These findings are puzzling. Adoption is complicated; when racial difference is added, one would expect to find additional difficulties. There is also anecdotal information about very serious difficulties experienced by transracially adopted individuals who seem unable to find a place in either the world of their adoptive families or the world of their birth families. The findings are subject to varied interpretation. On the one hand, the follow-up research provides evidence that transracially adopted children adjust as well as other adopted children and that most do not experience overt problems in adolescence or young adulthood. The adjustment measured is, of course, adjustment to the mainstream society. It is also possible, however, that the findings are reflecting a superficial adjustment that young people maintain in order to conceal from themselves the depth of their own concern about racial identity and that this adjustment will break down under the stress of adult life. Empirical work provides a good deal of information about childhood, less about adolescence, and to date very little about the adult lives of these adoptees. It is a line of research that will be important to follow.

Policy Implications The empirical evidence shows that no demonstrable harm comes to children who are transracially placed. Evidence clearly shows that great harm comes to many children who spend long periods in foster care. As long as we believe that the purpose of adoption is finding homes for children, transracial adoption is an option we are obligated to use.

Transracial adoption has implications for the society we are trying to build. Of course, we must commit resources so that all groups in our society and world have equal capacity to raise their children. But transracial adoption also helps us build a world in which differing peoples interact. It may be that these youngsters, with their identity based in two cultures, will grow into adults who build bridges toward better understanding.

International Adoption

Though there was some international adoption after World War II, international adoption on a large scale began in the aftermath of the Korean War.[14] Adoptions across international borders usually take place when the population of a country, due to poverty, war, or governmental policy, contains many children separated from their parents. Poorly developed child welfare services and poverty make it difficult for the government to care for its children. The adopting parents are from wealthier countries, have a belief that children are best raised in families, and are willing to surmount multiple bureaucratic obstacles to complete an adoption.

Ethical Issues These adoptions also raise ethical and policy questions, as well as revealing gaps in knowledge. The ethical issues center on the lack of choice and imperfect protection that biological parents may have and on poorer countries being compelled by economic issues to send their children to more wealthy countries. Until all countries can provide the family support and child welfare services to provide birth parents with real choices, these adoptions will continue to be questioned. Additionally, international adoptions "find children for

parents" rather than finding the most appropriate resources for children.

However, there is little doubt that international adoptions provide vastly improved opportunities for those children whose parents are unable to care for them, particularly if the best option their own country provides is institutional care. Poverty is extreme in many of the sending countries, where income supports or other supports for family living are minimal. Reports from Romania, for example, suggest that many families gave up infants to the orphanages, and then to adoption, because they were simply unable to feed additional children. Again, the answer is the development of family and children's services in these countries, and again, children cannot wait.

Numbers About 25 percent of adopted children have been adopted internationally, and 84 percent of these are transracial adoptions (Vandivere, Malm, and Radel 2009). International adoption gained steadily in popularity until 2004, when there were 22,900 adoptions, more than double the number in 1991. The number of international adoptions then began to decline, with 7,013 in 2013 (U.S. State Department 2014). The reasons are as varied as the sending countries. The countries that "sent" the most children to the United States for adoption in 2012 were China, Ethiopia, and Russia. In China, population control policy mandating only one child per family, in combination with an organization of society that favors male children, led to many girls being abandoned to state care; recently, there has been relaxation of these family restrictions. Russia stopped all adoptions in December 2012 citing concerns about the safety of children in the United States, though there were also political issues involved.[15] South Korea, the Ukraine, and Guatemala have in recent years sent large numbers of children; Guatemala stopped sending children in 2010 in the wake of concerns about pressure on birth parents to relinquish children.

The Adoption Process As noted earlier in the chapter, international adoption is expensive, and some of the expense may be questionable. In addition to fees that the adoption agency may charge, and depending on the laws of the country in which the child lives, there may be costs for air travel for the adopting parents, as well as living expenses and legal fees in the foreign country while the adoption is processed. A survey by the Evan B. Donaldson Adoption Institute found that 14 percent of the adopting families said the adoption cost more than the agency had told them it would cost, and 11 percent said overseas agency facilitators had asked for additional fees that had not been disclosed by the agency (Evan B. Donaldson Adoption Institute 2002c). The survey also revealed that almost three quarters of the adopting families were asked to carry cash, usually $3,000 or more, for anticipated fees and expenses. Whenever undocumented expenses are required for adoption, suspicion arises.

Independent adoptions have accounted for a large proportion of international adoptions, and this lack of regulation has drawn much criticism.[16] An agency that has links to a foreign country and specializes in adoption can make the experience much easier. Many adoption agencies specialize in international adoption; some have a long tradition of excellent service, while others have more questionable practices. All work in cooperation with child-caring institutions in other countries, over which they have no control. A review of international adoptions reported that 14 percent of adopting parents felt that the agency had given them inaccurate information about the child, 14 percent had received inaccurate information about the adopting process, and 13 percent would not recommend their agency to other families (Evan B. Donaldson Adoption Institute 2002c).

Despite these troubling survey findings, the sound and innovative work of many nonprofit adoption agencies should be recognized. Two good indicators of the professional responsibility of an international adoption agency are the

degree to which it is involved in the development of child welfare services in the sending country and the extent to which it provides post-adoption services to both parents and children to support the adoptions it has arranged.

Outcomes One of the interesting things about the controversy concerning international adoptions is that for many years there was little debate about the outcomes of these adoptions. Studies in the United States consistently found that children adopted as infants or very young children were developing well, with, as is true of domestic adoptions, somewhat more problematic adjustments for children adopted when older (Fiegelman and Silverman 1983; Altstein and Simon 1991; Benson, Sharma, and Roehlkepartain 1994).

Adoptions from Romania and some of the Eastern European countries raised a new concern. Many of the children in these adoptions had been cared for in large institutions and had experienced profound neglect as young infants. Developmental delays were common, and there was thought to be risk of attachment difficulties (Groze and Ileana 1996). Recent longitudinal studies offer insight into the impact of early institutionalization and the healing power of adoptive homes (Howard, Smith, and Ryan 2004; LeMare, Audet, and Kurytnik 2006; McGuiness and Dyer 2006; Colvert et al. 2008), finding severe developmental impairments that the children were able to overcome if they were adopted in early infancy (before six months or earlier). If adopted later, these delays would linger but become less over time. These follow-up studies found that about 20 percent had serious problems at follow up, and about 20 percent were doing very well. Despite difficulties, parents expressed satisfaction with the adoptions, and the families were stable.

Identity: Cultural, Racial, and Adoptive The racial identity of the children of international adoption has come into focus in recent years as the adoptees have reached adolescent and young adult years and begun to give voice to their experiences, which include a good deal of anger about being separated from their homelands. The transracially adopted children face the dual challenge of establishing a cultural identity different from that of their community and a racial identity different from that of their families, as well as learning how to manage discrimination. Baden (2007) reports the initial testing of a model of racial and cultural identification; her findings, based on data generated by fifty-one young adults, suggest that cultural and racial identity are highly correlated and that a variety of identities are developed by these adoptees. Neither identification with the culture and race of the adoptive parents nor identification with self culture and race predicted better psychological adjustment; the author suggests that identity may be less important than theorists have predicted.

Another facet is identity as an adopted person, which seems closely linked to racial identity. McGuiness et al. (2009) trace the identity development of Korean adoptees, beginning in grade school and growing in importance through adolescence and young adult life. The trajectories of concern about racial identity and identity as an adopted person are almost identical. Comfort with racial identity was associated with having experienced less racial teasing, coming from more diverse communities and more functional families, and having more positive life satisfaction and self-esteem as adults (McGuiness et al. 2009). Feigelman (2000) reports that young adult adjustment of children adopted from Korea, Vietnam, and Columbia is similar to the adjustment of those domestically adopted. Again, growing up in a diverse neighborhood had a positive impact.

This confirms the ideas of those working with international adoptions that the most meaningful experiences for adolescents and young adults are "lived" experiences in which they have opportunity to interact with those of their country of origin. Some agencies have established trips to the country of origin and

summer camps to provide these opportunities. These are very complex needs, and one is concerned about the experiences of families that adopted through agencies that do not provide post-adoption services.

Creating Safeguards Both supporters and critics of international adoption stress the importance of bringing order to this relatively unregulated enterprise. Those who think of international adoption as a resource for homeless children focus on the need for licensed agencies to make home studies of potential adoptive homes and to provide preparation and post-adoption support. Those concerned about adoptive parents note the barriers they face: different procedures for adoption in each country, immigration restrictions, travel, and long periods of uncertainty. Those who are concerned about the rights of birth parents emphasize the need to be sure that children are orphans or that parents have had a real choice in consenting to adoption. All parties wish to exclude unscrupulous intermediaries who seek to profit from adoption.

The lack of regulation has been addressed by the Hague Adoption Convention, discussed in chapter 2. The Hague Adoption Convention makes the sending country responsible for ensuring that the child is legally freed for adoption and that adoption is appropriate for the child. Other provisions of the act require that medical and other records be preserved and that only reasonable costs and expenses be charged for adoption. The receiving country must ensure that an adoptive home has been approved by an accredited agency or representative. It is hoped that this framework will stimulate countries to work more cooperatively, that duplicative processes will be eliminated, and that additional regulation will protect all parties to these adoptions.

Open Adoption

Open adoptions have been common in the United States only since the mid-1980s. Professionals, sensitive to the expressed need of many adopted adolescents and adults to know their own families, have generally thought open adoption a good idea as long as both the birth and adoptive parents are comfortable with the arrangement, and the number of these adoptions has grown rapidly. The public, generally accepting of different forms of adoption, is more conservative on this subject. In a survey of opinions about adoption, respondents were ambivalent about open adoptions, with only 21 percent thinking it a good idea in most situations, while 47 percent thought it a good idea in some cases (Evan B. Donaldson Adoption Institute 2002a).

Several streams of adoption work came together to foster the development of open adoptions. Perhaps most important, agencies heard adopted adults and adolescents saying emphatically that they wanted to know their birth families and saw the distress that closed birth records could cause. At the same time, the growing scarcity of white infants available for adoption put more power in the hands of birth mothers, many of who felt more comfortable if they knew where their child was going and could keep some contact through the years. Older children were being placed in adoption; many knew their original families and had some contact with relatives. It became evident that this contact could be absorbed into the adoption experience. Adopting parents were aware of all of these trends and recognized that their best hope of adopting the child they wanted was through accepting the wishes of birth mothers. They saw that open adoption, while different from the adoption they had imagined, might be good for their adopted children and workable for their families.

Numbers Most private domestic infant adoptions now are open adoptions. A recent survey of adoption agencies that were placing infants in adoption found that only 5 percent were confidential adoptions. An additional 40 percent were mediated adoptions—in these adoptions, the agency retains a good deal of control over

the amount of contact. The remainder of the adoptions were fully disclosed, and 46 percent had a plan for ongoing contact (Siegel and Smith 2012). Adoptions from foster care also tend to have some degree of openness, as foster parents and birth family are likely to have known each other prior to the adoption.

A Continuum of Openness Open adoption is an umbrella term, used to cover a variety of arrangements ranging from minimal sharing of identifying information to continuing contact between birth parents and adopting families. It is distinguished from closed, or confidential, adoption, in which the identity of the birth parents and adoptive parents are concealed from each other. Fully disclosed adoptions are completely open, and there is usually some amount of continuing contact among birth parents, adoptive parents, and the adopted child. Mediated adoptions are open adoptions in which the adoption agency facilitates exchange of letters and/or pictures, but there is no direct contact, and the parties do not have identifying information about each other. In mediated adoptions, some adoption agencies screen communication among parties, some attempt to resolve disputes that arise, and some agencies act only as a contact point (Henney et al. 2003).

Decisions about the degree of openness are made at the time of placement. The degree of openness desired by birth or adoptive parents or by the child can change over time, and parties to the adoption need to be open to these changes. The literature stresses that any degree of openness is acceptable if it meets the needs of all parties.

Outcomes Though open adoptions are relatively new, the earliest adoptees are reaching young adulthood, and a body of research is beginning to build on the outcomes of these adoptions. An examination of this research can give us an idea of the known and anticipated benefits and risks to each of the members of the adoption triad.

Birth Parents Most of what is known about open adoptions is through the lens of the adopting parents—they are the easiest to find and interview. Typically, contact is arranged between birth mother and adoptive family, though it appears that about 20 percent of open adoptions may involve contact with birth fathers (Siegel and Smith 2012). Grotevant (2000), in a brief review of the empirical literature, concludes that birth mothers who have continuing contact with their adopted children experience more successful resolution of grief. Grotevant et al. (2013) report a longitudinal study with a national sample that included confidential, mediated, and fully disclosed adoptions. The birth mothers in their study who had open adoptions tended to feel positive about the adoption. As time passed, birth mothers' lives became more complex, many with marriages and additional children. An initial need for frequent contact moderated as they saw that the children were well cared for. Flexibility in renegotiating the expectations of each party to the open adoption seems to be important. In many adoptions, contact diminishes over time (Crea and Barth 2009). If contact continues, the birth parent can gain a sense of contributing to the child's well-being (Siegel and Smith 2012). Birth parents with contact with the adoptive child and family have more positive outcomes than those in closed adoptions, feeling more satisfied with the adoption and with their role (Grotevant et al. 2013).

Once she has consented to the adoption, the birth mother is the member of the triad with the least power. When there are difficulties or disagreements, the adoptive parents can set the conditions, though results of a twelve-year longitudinal study show that this control diminishes over the years as adolescent children begin to set the terms of contact (Crea and Barth 2009). Anecdotally, birth mothers tell of adoptive parents who refuse to give them as much contact as they would like. Anecdotally, adoptive parents tell of birth parents who "drift away" over time.

Adoptive Parents Open adoption was expected to be more difficult for adoptive parents than for other members of the adoption triad. It was thought that the presence of birth parents would have a negative impact on their sense of entitlement to the child and that it would enhance their fears that the birth parents might reclaim the child. These fears have not been borne out. In fact, increasing levels of openness seem to be associated with lessening of fears about losing the child (Siegel and Smith 2012). Most adoptive parents report satisfaction with the open adoption (Siegel 2008; Crea and Barth 2009; Grotevant et al. 2013).

Early in the adoption, the adoptive parents' satisfaction with open adoption is related to their sense of control over the frequency and nature of contacts (Berry 1993). A source of disappointment for some adoptive families who value the birth mother's role in the adoptive family's life is the birth mother who, over time, maintains less contact and may eventually disappear (Reitz and Watson 1992; Grotevant 2000). Longitudinal research has shown that by the time the children are adolescent, this disappointment has changed into empathy and acceptance of renegotiating contact (Siegel 2008; Grotevant et al. 2013).

One concern raised by adopting parents is the impact of differing levels of contact among adopted siblings, with the fear that if one sibling had notably less contact with the birth family, it would make that child feel inferior. Children, however, seem more matter-of-fact about this. Adoption is discussed freely in open adoption homes, and differences in contact are a vehicle for this discussion. Moreover, biological relatives of one child seem to include siblings in their contacts (Berge et al. 2006).

Follow-up studies with adopting parents whose children are now adolescents or young adults indicate that parents are satisfied with the adoptions. The information provided through knowing the birth family is valued by adoptive parents. Indeed, in some fully disclosed adoptions, with continued visits, the adoptive parents "view birth family members as part of their extended family system, are committed to staying in touch with them, and are able to maintain clear boundaries and roles" (Siegel 2008:373).

Adopted Children Most adopting parents, birth parents, and professionals who participate in open adoption believe that the arrangement is good for the children. It is expected that knowing the birth parent will resolve children's questions, enable them to incorporate both the social heritage of their adoptive family and their biological heritage, and enable them to locate biological family without searching. The openness should promote healthy interactions within the adoptive family, and the child who knows all the parties to the adoption should be better able to develop a positive sense of identity.

In their national study, Grotevant and McRoy (1998) interviewed 163 children between the ages of 4 and 12 in confidential, mediated, and fully open adoptions. Their conclusion was that knowing the birth parents neither enhanced nor damaged the child's adjustment and self-esteem. As adolescents, when asked about their experiences with open adoption, those who had contact with birth relatives knew the most about their birth families, and those with frequent contact had the most positive feelings about birth families (Grotevant et al. 2007). As part of another longitudinal study, Siegel (2012) interviewed young adults who had grown up in open adoptions and who, as adults, had taken on the responsibility of maintaining contact. The patterns of contact were varied and had varied over the time span of the adoptions. All were appreciative of the opportunity to know birth parents (Siegel 2012).

The Triad Open adoptions take thought and energy if they are to be a positive in the lives of all three partners in the adoption triad. The planning process for the open adoption is an important factor in the connection of adoptive and birth families, but lives do not remain

static—the initial agreements about contact may need continual adjustment. Birth parents may want more contact early in the adoption; adoptive parents may want increased contact as children become adolescent and begin to ask about biological families (Grotevant et al. 2007; Crea and Barth 2009; Siegel 2012; Siegel and Smith 2012). Collaborative relationships between adoptive and birth parents, with a focus on the child's well-being, fueled by mutual empathy and communication, are the key to sustained comfort with open adoptions (Grotevant et al. 2007; Siegel 2012). As the children of open adoptions become adult, they are beginning to take over the management of the contact with birth families; it will be interesting to follow this over the next years.

Open Adoptions of Older Children The open adoptions discussed in the preceding section, and the subject of most of the follow-up studies, have been largely adoptions of infants. Open adoptions of older children have certainly occurred for a long time—many of the children placed from foster care know their parents, siblings, and extended family. The impact of this knowledge has not been systematically studied. It apparently does not necessarily lead to post-adoption contact; children adopted from foster care are less likely than children adopted privately to have open adoptions (Crea and Barth 2009; Faulkner and Madden 2012). Meezan and Shireman (1985) found that foster parents were more willing to adopt when they knew the birth parents; later studies have also noted increased empathy for birth parents when adoptions were open with contact (Grotevant et al. 2007; Siegel 2012). In a California study of 1,396 adoptions of children ranging in age from infants to 16 years, Berry (1991) found that adoptive parents rated the behavior of children who had contact with birth parents more positively. Faulkner and Madden (2012) also found adoptions from foster care less likely to be open and suggest that the nature of the birth family's involvement with the child welfare system may explain this.

In adoptions from foster care, the questions about open adoption are complex. The children will probably have lived with their birth families and will have been removed from them due to abuse or neglect. Adoption will have occurred as a result of the birth parents' failure to make the changes that would have allowed the children to return. They have no voice in selecting the adoptive home. They do not have custody of the child and are not in a position to push for an open adoption. Thus, a collaborative relationship between birth and adoptive parents may be difficult to establish.

Some adoptions from foster care are open. In adoptions from foster care, when there is continuing contact, it is likely to include both child and adoptive parents, suggesting that this contact is focused on the needs of the child (Faulkner and Madden 2012). In an ethically questionable practice, rather than proceed through a trial and court termination of parental rights, birth parents are often promised continuing access to the child as a condition of voluntarily relinquishing parental rights.[17] The amount of continuing contact is usually established through mediation. Thus, an open adoption is created through agency action, with neither party to the adoption having much voice. As increasing emphasis is placed on adoption of children from the foster care system, the need to know more about these open adoptions emerges, as does the need to examine the ethical basis of this practice.

Critical Issue: Adoption Outcomes and Post-adoption Services

If we believe that adoption is child-centered, then the outcomes of adoption for children should determine its usefulness. Neither adoptive parents' satisfaction nor birth parents' loss should dominate the discussion, though both are important dimensions. Though adoption is complicated for children, and there is trauma in the separation that precedes it, one has to ask whether the alternatives are better.

Adoption Outcomes In specifying the outcomes we want for adopted children, we all probably start with the idea of children and youth who exhibit positive social behaviors, learn in school, and demonstrate attachment to the adoptive family. If we are looking for the impact of adoption itself, we probably need to distinguish between children adopted as infants and those adopted when older, who may have adverse experiences to overcome. We also want all adopted children to be spared adverse experiences after their adoption—abuse, neglect, poverty, household dysfunction, or dissolution of the adoptive family.

Questions about the outcomes of adoption began about twenty years ago with the recognition that adopted children were disproportionately represented in mental health settings (Haugaard 1998). Adoptees, composing 2 percent of the under-18 population, composed 5 percent of mental health referrals and 10 to 15 percent of those in residential care settings (Sharma 1997). The alarm set off by these statistics raised questions about whether adoption was a good plan for children. Controversy about some nontraditional adoptions deepened unease. These statistics were and remain puzzling, as follow-up studies with nonclinical samples continually showed that the "link between adoption and adjustment problems is modest or nonexistent" (Haugaard 1998:48). Studies showed most children thriving in their adoptive homes, with families reporting good relationships and children doing well in school and community. A small proportion had serious difficulties. Little attention has been paid to adverse experiences after adoption, with the exception of disruption or dissolution of the adoption.

Adoption comes in many forms, as we have discovered in considering nontraditional adoptions. As we have also discovered, outcomes vary among these forms of adoption. Overall statements about adoption put all of these types together. Nevertheless, an overall picture can be drawn. When a large, nationally representative sample of adoptive parents was asked about their experiences with adoption, they were overwhelmingly positive. Most parents (81 percent) described a warm and close relationship between themselves and the adopted child. The parents report that 88 percent of the children exhibit positive social behaviors and also report that only 15 percent of the children have ever been diagnosed with a clinical psychological problem. School adjustment was a bit more problematic—as most of the follow-up studies show—with 69 percent of the children reported to care about doing well and doing required homework (Vandivere, Malm, and Radel 2009:32–35). These percentages paint a general picture much like that of earlier studies. Studies do consistently show better outcomes for infant adoptions. As at least a part of our question is whether adoptions are themselves adverse experiences, we will begin by looking at outcomes of infant adoptions.

Infant Adoptions Studies of nonclinical populations of infant adoptions have not found high rates of adjustment difficulties. Children adopted as infants seem to have more difficulties during adolescence than do non-adopted youth, with boys in particular having school difficulties and adolescent acting-out behavior, but that these problems were "still well within the normal range of behavior" (Brodinsky 1984; Haugaard 1998; Howard, Smith, and Ryan 2004). Another nationally representative study finds emotional and behavioral difficulties are present for approximately 10 percent of children adopted as infants (Vandivere, Malm, and Radel 2009).[18]

Howard, Smith, and Ryan (2004) focused on the experience of adoption. A sample of school age children adopted through the three paths—private infant adoptions, international adoption, and from foster care—was compared with a group of families with birth children. The birth family sample was relatively small, and it is not clear how representative it is. Consistently, the children adopted as infants were identified as having significantly more difficulties than the

birth group, the internationally adopted children having even more difficulties, and the children adopted from foster care as having the most difficulties.

It is the adopted adults who have grown up in traditional, confidential adoptions who have done a great deal of writing about the experience of growing up adopted and of the quest to find birth parents.[19] Most of the writing is an examination of the "inner self," and most of it focuses on the aspects of adoption that create differences and discomfort. To a large extent, it is critical of the adoption system, particularly the separation of birth and adoptive families, rather than of adoption itself. It is impossible to determine how typical these accounts are.

Adoption of Older Children Children adopted when older do bring more emotional issues and behavioral patterns to the adoption than do infants, and thus adoptive parents need extra flexibility, patience, commitment, and creativity. These children probably also have had adverse experiences and have experienced trauma. Early findings showed that children older when placed in adoptive homes were more likely to have serious difficulties (Kadushin and Martin 1988:614–21), and that finding has been sustained.[20] Children adopted from the foster care system are the group most likely to be older at adoption, and the follow-up studies that document the difficulties that adoptive families are having consistently show that this group has the highest percentage of problems (Howard, Smith, and Ryan 2004; Vandivere, Malm, and Radel 2009).

Though adoptions from foster care consistently showed the most problems, it should be noted that this group also had the largest number of older adopting parents, single parents, and parents with low income (Howard, Smith, and Ryan 2004). The highest proportion of chronic health problems and disabilities was found among children adopted by foster parents (Howard, Smith, and Ryan 2004; Vandivere, Malm, and Radel 2009). In other words, the children with the most special needs were adopted by parents with potentially the fewest resources.

When an Adoption Fails: Adoption Disruption and Dissolution

Adoption disruption is the term used for an adoption in which the child is removed from the adoptive home prior to the legal finalization of the adoption—this is usually within a year or two of the placement of the child for adoption. Adoption dissolution refers to the termination of an adoption after it has been finalized.

Because there is little data that tracks adoption through the years, the information we have about adoption dissolution is mostly the anecdotal stories of extreme distress. Festinger (2002) attempted to discover dissolution rates by following a sample of 497 children adopted in New York City. Of these, she found only two who were out of the home and not expected to return. Two other attempts to track adoption dissolution found similarly low rates (Goerge et al. 1997; McDonald, Propp, and Murphy 2001). Adoption disruption, occurring before the adoption is finalized, is easier to track. Though most traditional infant adoptions succeed, with a disruption rate of only about 2 percent (Kadushin and Martin 1988; Festinger 2005), as older children and children with special needs have been placed, overall rates of adoption disruption have increased. Reviews of existing studies of special-needs adoption estimate that the adoption disruption rate for children placed when older is between 5 and 15 percent (Rosenthal 1993; Barth, Gibbs, and Siebenaler 2001; Evan B. Donaldson Adoption Institute 2004). The resounding finding from these studies is that the younger a child is at adoptive placement, the more likely it is that the adoption will be stable. This, of course, makes sense, for the older a child is, the more years there have been for the accumulation of experiences of disrupted attachments. It is a powerful argument for moving children as rapidly as possible into permanent homes.

Studies of adoption disruption find that the most often cited reason that parents ask to have a child moved is their inability to manage the children's problems, demands, and behaviors, combined with unmet, and often unrealistic, expectations (Partridge, Hornby, and McDonald 1986; Festinger 2005). Attachment difficulties are part of the picture; the child does not reward parents' efforts with affection or behavioral changes. Adoption disruption takes place in a fashion similar to that of the disruption of a foster care placement—a long time of difficulties and diminishing pleasure, identification of the child as the problem, and then a critical incident, and a decision not to continue (Partridge, Hornby, and McDonald 1986:61–62). Post-adoption services can be useful in interrupting this progression and salvaging the placement: Illinois adoption preservation services, offering intensive intervention similar to family preservation services, are an example (Smith 2006a). And often a child that has participated in an adoption that did not work can move on to another adoption that will be successful—there has simply been a mismatch between the child and the adoptive parents (Festinger 2005).

Post-adoption Services

With the end of the era of thinking that adoptive families were "families just like any other families," post-adoption services began to develop: books, support groups, and counseling services. As nontraditional placements became common, with multiple needs and problems expected, professionals recognized that the support that foster families needed would also be needed by adopting families. And, as the needs of adoptive families differed, and differed over time, it was important that there be a range of post-adoption services.

Parents' Perceptions of Needs Though these post-adoption services have been in place for many years, beyond the reports of adopting parents themselves, there is little evidence about the effectiveness of the various services. Parents tell us that the most important services are (1) support services, including support groups and informal contact with similar families; (2) parenting education; (3) respite care and child care; (4) counseling; (5) services for children, including groups for older children; and (6) adoption assistance (North American Council on Adoptable Children 2009). Additionally, adoptive parents interviewed by Howard (2006) identified financial need, beyond the amounts of adoption subsides.

Adopting parents report that they are particularly likely to need supportive services soon after the adoption and when there has been a traumatic event in the family (Dhami, Mandel, and Sothmann 2007). The need for post-adoption services can occur many years after the adoption; families may return for services several times (Lenerz, Gibbs, and Barth 2006). Adopting parents feel that they need more services than are provided, and those who were foster parents identified many services that they lost when they adopted (Festinger 2006).

Educational and Informational Services Used by many adoptive families, educational and informational services are often thought so basic that they receive little attention. They include books, articles, lectures, and workshops. Books and articles are the most frequently used post-adoption resource, used by 82 percent of families in one large survey (Brooks, Allen, and Barth 2002). However, the same survey found that for families adopting from public agencies, reading was not as helpful (pp. 232–33). Their problems were more unique and complex.

Support Networks Many adoptive parents utilize support groups, or contacts with other adoptive families, and find them among the most helpful post-adoption services available. Asked how they would design post-adoption support services, more than 60 percent of adoptive families included support groups, and 60 percent included classes, which are

educational and also have a social component (Brooks, Allen, and Barth 2002).

Many support groups are specific to nontraditional adoptions, such as transracial adoption, open adoption, or international adoption. Other support groups are organized around the difficulties of adopted children who have special needs. A support group reduces the sense of isolation, in addition to providing practical, parent-tested ideas for problem solving. One responsibility of an adoption agency is to ascertain the support an adopting family has within the family and community system and to link adopting families to appropriate adoption support groups.

Support groups may be initiated by adoptive parents, sponsored by adoption agencies, or supported by state agencies. Several national organizations that focus on adoption, such as the North American Council on Adoptable Children (www.nacac.org), have webpages with information on finding or starting a support group—as well as other information of use to adoptive parents.

Barth, Gibbs, and Siebenaler (2001) note in their review of the effectiveness of post-adoption services that contact with support groups or with other adoptive parents has proved useful. Brooks, Allen, and Barth (2002) report, from their survey of 873 adoptive parents, that 70 percent found support groups helpful. This is one of the least intrusive and probably least expensive of the post-adoption support services, and the energy that has gone into establishing support groups is testimony to the wide recognition of their usefulness.

Counseling and Other Clinical Services In the past, families who turned to community mental health services were often frustrated by providers' lack of understanding of the issues raised by adoption and by their tendency to attribute any difficulties to the interactions of the current family. Bourguignon and Watson (1987) identified for mental health professionals the issues faced by adopting families (whether they adopt an infant or an older child). Chief among them were the grief and loss felt by the child and the need for resolution of those feelings before the child could truly become part of a new family. The authors argued that these families needed a combination of support for the adoptive parents and direct help for the child. Recognizing that these concepts are unfamiliar to most mental health service providers, adoption agencies have increasingly assumed responsibility for providing post-adoption services, either directly or by contracting with mental health service providers with expertise in adoption.

Post-adoption clinical services take many forms. Family therapy approaches are based in theories, such as those put forward by Bourguignon and Watson (1987), that emphasize the uniqueness of the adoption process, in which children (of any age) bring their family ties and history into the new family and in which both children and adoptive parents experience feelings of loss that must be worked through. Related are the trauma-informed models in which parents begin to view their children in the context of all that has happened to them, and children begin to develop the resilience that will enable them to move beyond their experiences (Blaustein and Kinniburgh 2010). Cognitive behavioral theory informs many of the crisis-oriented, brief family preservation models that have been used when adoptions are close to disruption, though problems are often so intense that the time period of the intensive therapy is greatly extended (Smith 2006b). All of these approaches involve direct work with the child as well as with the caregivers.

To date, we have no empirical evidence that any one approach is superior to the others. Barth, Gibbs, and Siebenaler (2001) note that few post-adoption support programs have conducted formal evaluations of their own effectiveness. Based on their review, they suggest that brief family preservation models do not fit the needs of adoptive families as well as more extensive, family-focused treatment models. Haugaard (2006) notes the need for studies of

post-adoption services in which there is a control group, so that actual effectiveness of services can be tested.

Out-of-Home Care Temporary placement outside the adoptive home is an effective post-adoption service in some extreme situations, but as attachment difficulties may be part of the problem, placement is used with great caution. The range of group care facilities discussed in chapter 7 are used to help adolescent adopted children who are struggling to fit into their families and communities. The most progressive residential care programs increasingly involve adoptive families in their children's treatment programs. More than half the states say that they provide residential treatment as a post-adoption service (Barth, Gibbs, and Siebenaler 2001), an indicator of the severity of difficulties of some children.

Respite Services Discussed in more detail in chapter 4, respite care is another post-adoption service. In the context of adoption as in other settings, it is a temporary service, focused on enhancing and stabilizing the relationship between parent and child. It is a service that adoptive parents frequently identify as a need (Festinger 2006). Respite services can facilitate the formation of strong adoptive families. For example, respite care can be critical in enabling a family to continue to care for an adopted child with serious disabilities or with severe behavioral problems. The constant demand of the care of such children can exhaust parents, leaving them with the feeling that the only solution is to ask the placing agency to take back custody of the adopted child. Respite care can provide just what its name promises—a time for parents to regroup, to regain energy and commitment, and to attend to other family business.

Adoption Subsidies As agencies began to focus on the needs of older children and children with special needs for permanent homes, it became evident that one of the barriers to adoption was family income sufficient to meet these children's needs. Foster families who had been caring for children emerged as a good source of adoptive homes for these children, but many of these families had marginal financial resources and would be unable to adopt if they faced the loss of income from foster care payments (Shireman 1969). A few private agencies developed adoption subsidy programs to make it possible for families to adopt children with serious and expensive medical problems. In 1968, New York became the first state to enact legislation making adoption subsidies widely available. Other states rapidly followed.

In 1980, Congress passed the Adoption Assistance and Child Welfare Act, which—among its many provisions—encouraged states to make subsidies available to families who adopted children with special needs, provided a 50 percent federal match for state adoption subsidies, and guaranteed Medicaid insurance coverage for those children. Additional federal funds are available through the Promoting Safe and Stable Families program of Title IV-B of the Social Security Act.

Most state laws provide that in order for a child to be eligible for a subsidy, (1) the child must have "special needs," that is, must be older, a member of a minority group, part of a sibling group, or have a disability; and (2) an attempt must have been made to find a home that does not need subsidy. Subsidies can be adapted to meet the needs created by a specific disability, but more usually they are payments to supplement income for the daily care of the child. The amount is based on the child's need and the family's resources, and yearly review is usually required. Subsidies are also available to foster parents who assume guardianship of a child.

The policy issue that has plagued the implementation of adoption subsidies is the question of whether the subsidy is part of the placement planning for a specific child, in recognition of special needs, or whether it is dependent on the economic resources of the family. In the early days of subsidized adoption, it was hoped

that the subsidy could be attached to the child, whatever the circumstances of the adoptive home. But this approach did not meet the needs of budget-conscious administrators or legislators. What has evolved is a formula that varies by state and factors in both needs of the child and the economic resources of the family.

Adoption assistance has been particularly important in making it possible for foster parents to adopt the children who have been in their care. Subsidies also play a role in increasing the number of homes available for minority children. A post-adoption study that included many African American adoptive parents revealed how close to poverty many of these homes were; adoptive parents listed more generous subsidies among their needs (Festinger 2006).

Building a Comprehensive Service System

Ideally, adoption agencies would work with the families who have adopted, and with young people who have been adopted, to design optimal post-adoption support services. What would the service design look like? The "home" of such services might be an adoption agency, a family resource center, or another community agency. It is critical that there be some central place that families can contact to find out where to go for help; this is identified by adopting parents as a major need (Festinger 2002).

Services should be comprehensive. A 2002 survey (Brooks, Allen, and Barth 2002), for example, suggests that most adoptive families want, and will use, informational and support services, while a relatively small proportion want therapeutic services. Some families need more than counseling, benefiting from family preservation services and sometimes temporary residential care for a child. All these should be part of the network of available post-adoption services.

In describing effective adoption preservation services, Smith (2006b) lists "guiding principles"; many (such as start where the client is) are familiar to social workers. Others are more specific to post-adoption counseling. "Be accepting and non-blaming" is the first; adoptive parents are all too familiar with traditional parent training and family therapy models that assume the problems are rooted in poor parenting. Others, such as educating the parents to understand their child, and joining with and empowering parents, emphasize the dynamics of work with adopting families. Smith (2006b) also writes of the importance of linking families to community services.[21]

There is, thus, a wide range of post-adoption services that are offered by some agencies in some communities. They are services that adopting parents tell us they need. With the development of the Internet, new services, particularly support groups, are developing constantly. Though adopting parents report satisfaction with these services, we have little research to tell us which services are most effective for what types of issues. "Adoption is a lifelong process" the slogan says. If so, adoption agencies need to be sure that support services are available in their community through the years.

Adoption as a Plan for Children

These many studies seem to tell us that there is something different about adoption, but we don't quite know what it is. Adoptions are very stable; disruption rates are low. However, about a quarter of the families that remain intact struggle with serious problems.

Adopted adults tell us, as they search for their birth parents, that identity is the issue, or at least they tell us that they need to know their biological parents to have a sure sense of who they are. Two very early studies of same-race infant adoptions suggested that identity was not an issue; the adopted children seemed to be just like the birth children on that dimension (Stein and Hoopes 1985; Sharma 1997). Racial identity is, of course, a continuing concern in any transracial adoptive placement. Children in open adoptions with contact know their biological parents; interviews with these children when they have become adults should provide data to help assess how important a factor this is.

The second big issue for adopted children seems to be attachment difficulties. Children who have experienced neglect or abuse have developed defenses for survival, and they do not trust adults readily. Children who have had attachments disrupted by frequent moves may be reluctant to form new attachments. This is hard for adoptive parents, who are eager to bond with the child, and may be a cause of considerable stress. Children will have to learn to trust the new parents and can then begin to develop secure attachments. This may take time, and the child may need professional help with the task.

Consistently, studies tell us that children placed into their adoptive homes when they are older have more difficulties growing up adopted. These children have had serious experiences of abuse and/or neglect in their original homes or (in international adoption) in institutional placements. In chapter 2, we explored the lasting impact of such experiences on child development. Adoption is not the entire cause of the difficulties these children have. The proper comparison group for these children is not children growing up in birth families; it is children growing up in foster care. Chapters 7 and 9 have a great deal of information about outcomes for these children. Adoption outcomes are much better; the stability of the adoptive home helps.

Internationally adopted children and transracially adopted children, though they display the same externalizing behaviors as other troubled adopted children, may have an additional dynamic in play. There is an undertone (sometimes overt) of anger, even among those who seem to be conforming. It seems to be anger at being placed in a situation in which they are made to feel disadvantaged due to their race—African American, Latino, or Asian—in a white society. Adoption has been openly discussed in these families—there was no avoiding it when the children looked different—and the hope was that this open communication would be healthy and would help the children avoid difficulties. The impact of a racist society has apparently overridden this dimension. Families were urged to live in multiracial neighborhoods, but few did. It may be that it is not adoption, but racial difference, that is the core issue. Yet, follow-up studies show many transracially adopted children doing well.

Most adopted parents and children do not experience these very difficult problems. Protective factors seem to be an easy-going nature and resilience in the child, so that changes in living situations and the demands of adoption are better weathered. The support of the family's network—relatives, friends, church, neighborhood—is important. A match of parental expectations to the child's abilities and capacities is important, as is parental flexibility in modifying expectations. And that flexibility can be a protective factor as it extends to learning from the child and modifying parenting behaviors to find the most effective match.

If adoption is viewed as a child-centered institution, the key question is, "Is it a good solution for children who cannot remain with the families into which they were born?" The short answer is yes, with qualifications.

Conclusion

This is an exciting time for those involved in adoption. Earlier stigma seems to be disappearing. The public has a favorable opinion of adoption, though there may be doubts about some non-traditional adoptions. At the same time, the voice of adopted adults searching for birth parents and the recognition that some adopted families struggle with serious behavior problems suggest that there are unrecognized issues in adoption and a need for greater understanding and development of complementary services.

Adoption is a child-centered institution. The most exciting development of the past forty years is, without question, the realization that a permanent home should be found for every child, and that one can be found for almost every child. This philosophy has guided the increasing number of adoptions of children

from the foster care system—now more than a third of all adoptions. This quest has stretched the thinking of professionals working in adoption and opened the public mind as it reacts to adoption. The challenge is to extend this child-centered philosophy to all adoption.

The ability of nontraditional families to embrace children with unusual needs and to meet those needs has been demonstrated over and over again. The controversies are real, and the policy questions are difficult. However, if we have learned anything in these years, it is that we should greet each new form of adoptive family with warmth and support and learn which children they can best parent. This is, indeed, the route to finding a home for every child who needs one.

As children with increasingly complex needs are placed in a variety of adoptive homes, and as a new openness pervades adoptions, the need for post-adoption services that continue to be available through the life of the adoption becomes evident. It is to be hoped that the recent federal emphasis on adoption, including federal bonuses to agencies for completed adoptions, is an indication that post-adoption service will be adequately funded. It is also to be hoped that public policy will support the integrity of the adoptive family, not by neglecting the rights of birth parents but by recognizing that adoption is a good plan for most children and a much better plan than the alternatives if a child cannot live with his or her birth family. Certainly, the United States, with its historic emphasis on opportunity tied to individual effort rather than inheritance, is a country that can increasingly support adoption for children.

NOTES

1. Interest in family genealogy was sparked in part by the publication of Alex Haley's *Roots: The Saga of an American Family* (New York: Doubleday, 1976) and the popular television series that followed.
2. This study will be referred to frequently in this chapter. As a module of the National Survey of Children's Health, it is a nationally representative sample of adopted children whose parents participated in a telephone interview about their adoption experience. Stepparent adoptions were excluded from the sample.
3. An Oregon farmer, Henry Holt, sparked interest in international adoption when, learning of abandoned children in the aftermath of the war in Korea, in 1955 he and his wife, Bertha, urged an act of Congress that enabled them to adopt eight Korean orphans. In 1956, after returning to Korea on a mission to unite more orphans with American families, he founded Holt International. That agency has pioneered international adoption and has been instrumental in the development of child welfare services in multiple countries.
4. Carp (1998:138–195) provides a thoughtful history of this movement.
5. The author must admit that the fact that she was a caseworker for many birth mothers in the 1960s, and made promises of confidentiality, influences her to see this as more of an ethical dilemma than do many authors. The Evan B. Donaldson Adoption Institute report cited here, an excellent review of the history and court decisions about the issue, may be more impartial.
6. Michael Shapiro's *Solomon's Sword* (New York: Random House, 1999) provides a thought-provoking examination of the protection of all three parties to an adoption. One of the book's central subjects is the attempt of a couple to adopt a child who is later reclaimed by her birth mother.
7. Ann Fessler's *The Girls Who Went Away* (New York: Penguin Books, 2006) was recommended to me by a birth mother as a good description of the experience. It is a collection of interviews with women who have placed infants in adoption; their experiences encompass the decision making, the placement, the years after the adoption, and some reunions. The experiences described are probably typical, and the stories illustrate the emotional turmoil and grief involved in the decision.
8. Although the basic characteristics of the study are the same, foster homes that are becoming adoptive homes need an adoptive home study. The study, however, focuses on the transition to adoption and its expected impact on all of the family members.
9. These conclusions are drawn from Hockey (1980), Coyne and Brown (1986), MacCaskill (1988), Pine (1991), and Glidden and Johnson (1999).
10. Vandivere, Malm, and Radel (2009) define rehabilitative services as family counseling; crisis counseling; mental health care or counseling for children; treatment in a psychiatric hospital, group home, or residential treatment center; and alcohol or drug evaluation and/or treatment for children (p. 48).
11. Brodzinsky (2011) reports that as open adoptions were being arranged, birth parents' reactions to

gay or lesbian couples was strongly positive, with gay couples being chosen more often. Birth mothers explained a desire to remain the "only mother."

12. The Indian Child Welfare Act remains in force as an exception to MEPA.
13. There have been longitudinal studies extending through adolescence (Simon and Altstein 1977, 1981, 1987, 1992; Shireman 1988; Vroegh 1997; Feigelman 2000; Feigelman and Silverman 1983) and "snapshots" taken during childhood (Falk 1970; Fanshel 1972; Grow and Shapiro 1972; Ladner 1977; Zastrow 1977) and during adolescence (McRoy and Zurcher 1983; Weinberg et al. 2004).
14. At the end of the Korean War, thousands of children born to Korean mothers and Western military fathers were stigmatized by a Korean society where racial purity was important. They were often abandoned to orphanages. Pearl Buck was a vocal supporter of American adoption for these children and adopted seven herself through the agency, Welcome House, that she established. Harry and Bertha Holt in 1954 saw a film about the hardships of children in Korea, decided they could give a home to some, went to Korea, and brought eight children home. The publicity that followed enhanced continued interest in international adoption.
15. This action followed some investigations of possible child abuse, and then the incredibly poor parenting decision of an adoptive parent, who sent a 7-year-old adopted child on a plane back to Russia, alone.
16. For a well-written account of the difficulties of independent adoption of a child from a Central American country and an analysis of policy issues, see Elizabeth Bartholet's *Family Bonds: Adoption and the Politics of Parenting* (New York: Houghton Mifflin, 1993).
17. For an excellent evaluation of the ethical issues of this practice and of open adoptions generally, see Reamer and Siegel (2007).
18. In calculating this, the author has made the assumption that most children privately adopted and internationally adopted were infants or very young children. Outcomes for infant adoptions may be even more positive than these data indicate, for many young children adopted internationally have been in institutional care and may have been neglected.
19. Betty Jean Lifton's *Journey of the Adopted Self: A Quest for Wholeness* (New York: Basic Books, 1994) is one of the best known of these accounts and is an fascinating book.
20. Major studies on which these findings are based are Triseliotis and Russell (1984), Nelson (1985), Festinger (1986), Partridge et al. (1986), Reid et al. (1987), Barth and Berry (1988), and Rosenthal and Groze (1992).
21. The Smith (2006b) article on services designed to preserve adoptive families in crisis presents excellent illustrative material on the difficulties of these families, as well as an elegant diagram on page 164 that describes this post-adoption service.

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9

Youth in Transition

WITH MIRANDA CUNNINGHAM

Thus it is not enough just to open the gates of opportunity. All our children must have the ability to walk through the gates.

—President Lyndon B. Johnson

The child welfare system historically worked with young people until they were established as adults. As a consequence of narrowing its mission and increasing focus on protective services for vulnerable young children, public child welfare now offers relatively little service to adolescents unless they have been taken into care in earlier years and have been in long-term out-of-home care or unless parents ask for help in managing behavior. However, adolescents are at a vulnerable point in their lives, a point of transition from the relatively protected status of childhood to the independence of adult life. This is a difficult transition. It occurs now over a longer time span than was common fifty years ago, partly because the conditions of employment make it more difficult to establish independence. It is a time when decisions can have lifelong consequences.

Part of this transition is experimenting with independence, and part of this experimentation involves risk-taking. Most adolescents, of course, manage their growing independence and the risks they take in such a way that they need no support and guidance other than that provided by their families and communities. Some adolescents, however, involve themselves in such risk-taking behavior that they are themselves at risk of what Schorr (1988) calls "rotten outcomes." The decisions they are making, the risks they are taking, may commit them to adult lives of poverty, substance abuse, ill health, and/or involvement in the criminal justice system.

This chapter will briefly outline some of the common problematic behaviors of adolescents, with the intent of giving the reader a sense of the vulnerability of this group of young people, leading to at least a few ideas about ways to strengthen the supports to youth during this transition time. Focus in the latter part of the chapter is on the struggles of youth that seem most directly connected with the responsibilities and knowledge of child welfare—the struggles of youth who have been in out-of-home care. The implications for programs to provide guidance and support during the transition to adult life will be explored.

The reader must recognize that each of the topics of this chapter could easily be expanded, and has been expanded by others, into articles, research reports, and books. Nonetheless, it seems important to include at least an overview of the difficulties of these youth, for they are part of the child population of our country and as such part of the charge of child welfare. And, when their difficulties become too much for families to manage, they come into the child welfare system: the age groups most frequently entering out-of-home care are infants and adolescents (Wulczyn et al. 2006).

Common Difficulties

Adolescence is the time of transition from child to adult. This is an immensely complicated task, involving gradual separation from the support of the family while adventuring

into a new world. Missteps are common. Commonly identified troubling behaviors of adolescence are early sexual activity; use of tobacco, alcohol, and/or drugs; association with delinquent peers; truancy and running away from home—all activities that can lead to negative outcomes. Increasingly, mental health issues are being identified. The residual effects of earlier trauma may complicate adolescent ability to cope with the complex tasks of the age. Services to address adolescent difficulties have to a great degree been relegated to the educational system, assorted private community mental health services, and, when the law is broken, to the juvenile justice system. Though the reader will find reference to these systems as adolescence is explored, the description and evaluation of these systems is beyond the scope of this book.

The public has been relatively acquiescent about the lack of a coordinated service system for this age. This is, after all, not an easy population to serve, and those exhibiting troubled behavior are not an attractive population to market. There are no heartwarming and photographic endings, as there is when a toddler goes home or a first-grader is adopted. For youth from well-functioning families with adequate resources, family support will see them through the transition—sometimes at considerable cost to the family. When family support is not sufficient, there are only youth attempting to find their own way, sometimes making themselves as different as possible from the community at large, and by their very difference provoking anxiety. And it is perhaps this anxiety that has kept in place what few services there are.

Risk Antecedents

Some youth are more vulnerable to problematic behavior than others. Settersten and Ray (2010) emphasize that the lack of community supports puts increasing stress on less affluent families and their transitioning children. Disadvantaged homes and communities are risk antecedents (Burt, Resnick, and Matheson 1992; Children's Defense Fund 2011). Not only does poverty increase the chances that youth experience poor schools and will not be connected to the opportunities of mainstream society, but also violence in these communities generates fear and resultant aggressive behavior, and youth have about them peers and role models who have themselves engaged in negative behavior. Even more vulnerable are children without families, either those who have grown up in out-of-home care or those who have found it impossible to continue to live with their families and have run away or been turned out of their homes. Sexual minority and ethnic/racial minority youth are disproportionately represented in many risk categories.

Achieving the Landmarks of Adult Life

In the United States, adolescence extends over a relatively long period of time A step at a time, adolescents move toward assuming adult roles. They begin to spend time away from the support and shelter of home, to engage in educational preparation for later work, and to be more independent in decision making.

> Becoming an adult has traditionally been understood as comprising five core transitions—leaving home, completing school, entering the workforce, getting married, and having children . . . the process of becoming an adult is more gradual and varied today than it was half a century ago. . . . Young people are taking longer to achieve economic and psychological autonomy than their counterparts did then. Experiences in early adulthood now also vary greatly by gender, race and ethnicity, and social class. (Settersten and Ray 2010:20)

Results of a 2002 survey developed by the MacArthur Research Network on Transitions to Adulthood indicated that the commonly identified markers of adulthood are completing school, establishing an independent household, and being employed full-time. Marriage and having children are now viewed more as life choices rather than as markers of adult status (Settersten and Ray 2010).

Since the 1970s, there has been a 70 percent increase in the number of young adults who have not established an independent living arrangement; in 2007, more than 40 percent of youth aged 20–24 were living with their parents. The percentage falls as youth age, but even at age 30, 12 percent of men and 10 percent of women were living with parents. The percentages are higher for African American youth and for youth from immigrant populations (Settersten and Ray 2010). Reasons for this shift are probably in the changing labor market, where there is increasing demand for workers with skills that demand technical training or a college degree. Additionally, high unemployment makes it difficult for unskilled workers to find jobs.

Most youth plan to attend some type of college or training after high school, but high schools are not holding their students until graduation. In the United States in 2008, 81 percent of white students graduated from high school, as did only 61 percent of African American students and 63 percent of Hispanic students. There is, then, a sizable proportion of young people who do not succeed in completing their education.

Dropping out of school has major life consequences. College graduates earn more than twice as much annually as those with only a high school diploma, and more than two and a half times the amount earned by high school dropouts (Children's Defense Fund 2011). Those that graduate from high school want an affordable postsecondary education. Community colleges have been important in meeting this need, and this continued education is one reason that youth remain longer at home. About a third of young adults complete four years of college, with, again, vast differences between white, African American, and Hispanic populations (Children's Defense Fund 2011).

Settersten and Ray (2010) note that this changing trajectory of the transition to adulthood has overwhelmed traditional resources, particularly educational resources. Community colleges are a relatively low-cost opportunity for preparation for multiple occupations or for transfer to a four-year university. They are going to need an infusion of public funds if they are to continue to be available. In addition to community colleges, Settersten and Ray identify service learning opportunities and the military as institutions that can connect youth to community and open opportunities.

With youth focused on education and thus delaying their earning of a livelihood and establishing an independent home, the postponement of marriage is inevitable. In 2010, the median age at first marriage for men was over 27, for women 26. Nearly 40 percent of first births occur before marriage; the majority to those with the least education and lowest incomes (Settersten and Ray 2010).

This delayed timeline for the establishment of adult roles means extended reliance on family for all forms of support. There are few public systems available to assist. There are vast inequalities in the resources that young people have during this transition, depending on the income and social status of their parents. Youth who do not have active family connections are at a tremendous disadvantage. It is not surprising that youth often lose their way during this transition.

Targeting of communities and families in order to create the conditions for youth "connectedness" is a relatively new policy direction that differs from that of providing services to youth that are at risk. With its emphasis on changing communities, it is a comfortable fit for social work.

Youth at Risk

When, for some adolescents, the difficulties of the transition to adult life have caused them to disconnect from society or to turn from a community that does not offer the supports needed, there is danger of behavior that puts the adolescent at risk—at risk of immediate health consequences or at risk of long-term disadvantages due to bad decisions. These are the youth that

are frequently the focus of our concern and our attempts at service.

Sexual Behavior

The sexual behavior issues of concern among teenagers today are the consequences of early sexual activity and of "unsafe" or unprotected sexual activity resulting in sexually transmitted diseases or unplanned teenage pregnancy.

Early Sexual Activity Using data from the National Study on Family Growth, researchers conclude "sex outside of marriage has become the norm for teens rather than the exception" (Averett, Rees, and Argys 2002:1777). More than 80 percent of young women ages 18 and 19 and more than 50 percent ages 15–17 report that they are sexually active, and of those who are sexually active, 80 percent report using contraception (National Research Council 2007). Fifteen percent of sexually active teenage girls have had more than three sex partners (IOM and NRC 2011). Contraceptive use by girls between 15 and 19 years seems to be related to neighborhood characteristics rather than personal factors or government policies (such as parental notification and consent laws, Medicaid funding for abortions, and the availability of family planning services) (Averett, Rees, and Argys 2002).

Early child bearing makes it much more difficult to complete education, and educational deficits can result in a lifetime of limited earnings. Birth rates to adolescents reached a peak in 1957, declined for several years to a low in 2000, and have changed very little in recent years. They are dramatically higher for Hispanic (80 per 1,000) and African American (60 per 1,000) girls than for white girls (25 per 1,000) (IOM and NRC 2011). Smith (1997) collected data from a longitudinal study of more than 800 urban youth of color and found that adolescents who had sex at an earlier age were more likely to practice unsafe sex and to have more than one partner. For girls, having two biological parents in the home was statistically related to delaying sexual activity, while substance abuse, low educational goals, and depression were significant correlates of early sexual activity.

Boys who had sex at a younger age were less likely to report using condoms and reported having multiple sexual partners (Smith 1997; IOM and NRC 2011). Also, boys who became sexually active at an earlier age were more likely to report impregnating a girl and were more likely to be fathers than boys who became sexually active later. The strongest predictors relating to boys' early sexual activity were child maltreatment and substance use (Smith 1997). These young men are likely to become absent fathers, depriving their children of the advantages shown to accrue to children in homes with resident fathers (Malm and Zielewski 2009).

Early Childbearing Four of every hundred teenage women become pregnant every year. (Children's Defense Fund 2011). As noted in chapter 1, young families headed by single mothers are the group with the highest rate of poverty—including about 5 percent who are extremely poor, facing hunger, homelessness, or insufficient medical care (Kalil and Ryan 2010). Their potential earnings are limited by educational and health issues. A national survey showed that almost half of unwed mothers lack a high school diploma and have higher rates of poor overall health, emotional problems, and drug use than do married mothers (Kalil and Ryan 2010). These mothers will rely on government programs and on a network of family and friends as they raise their children.

Young single mothers are the focus of many services. Abuse and neglect prevention programs often target them, teaching and supporting parenting skills. Several have been evaluated in randomized trials, and significant effects have been found in abuse and neglect, children's behavior, mother's economic well-being, and the time to the next baby. Long-term follow-ups have found differences in school success and arrest records. These programs are described in chapter 4. Welfare reform

targets these mothers, providing disincentives to early parenting and offering child care subsidies while the parent becomes self-supporting. Many school health curricula and other community programs emphasize the risks of early parenting and the rewards of waiting.

Fathers of these babies are young, often poorly educated, and have extremely low earnings. When a child is born, fathers are usually romantically involved with the mother, but over time these relationships often dissolve with only about a third of the fathers living with the child after five years (Lerman 2010), leaving the mother as the active parent. Policy initiatives to increase marriage were part of the welfare reform discussed in chapter 1. In 2001, the Administration for Children and Families launched a "responsible fatherhood" initiative, and federal budgets have included funding for these programs. Part of the goal of these programs is to increase the financial support fathers provide, and involvement of fathers in the lives of the children is also a goal. A number of these programs have evolved and have achieved modest success in increasing fathers' involvement, though few have been evaluated using control groups (Cowan, Cowan, and Knox 2010). However, absent fathers are sometimes more a part of the family than is easily recognized, and the relationship between the mother and father may be key to continued father involvement (DeParle 2004).

Birth rates for teen mothers are declining, though there are great disparities in these rates among the states. In 1990, almost 60 of every 1,000 teenagers gave birth; in 2009, the rate was 41.5 per 1,000 (Children's Defense Fund 2011). It is not clear whether this change is a response to educational programs concerning the advantages of delayed childbearing, increasing access to information about contraception, an indicator of a greater frequency of abortions, or is simply a change in teen culture.

Sexually Transmitted Disease and AIDS In a feature on adolescence, *Newsweek* reported that one in four sexually experienced teens acquire a sexually transmitted disease (STD) every year, equivalent to nearly 3 million teens every year (*Newsweek* 2000). Adolescents, aged 15–24, account for nearly half of all sexually transmitted diseases in the United States (IOM and NRC 2011). The rate of infection varies markedly by sex and race (for example, with boys less likely to be diagnosed with chlamydia, and African American adolescents more likely to be diagnosed than white or Hispanic adolescents) (Crosby and Danner 2008). Other STDs increase the likelihood of an HIV infection; *Newsweek* reports that almost one fifth of all reported AIDS cases are young people between the ages of 13 and 29.

Early onset of sexual activity, female gender, and minority status are all predictors of STD prevalence. Attitudes toward risky sexual behavior also predict the presence of an STD. The longitudinal design of the National Longitudinal Study of Adolescent Health (Add Health) allowed the discovery that these attitudes are remarkably stable, changing very little from early to late adolescence (Crosby and Danner 2008).

Although STDs are more preventable than most infectious diseases and exposure can be greatly reduced by condom use and by having fewer partners, sexually active adolescents may heighten their risk by using drugs and alcohol, thus lowering their ability to control impulsive behavior. Furthermore, many teenagers are unaware of having contracted an STD and may continue to infect others before receiving treatment.

Policy and Programmatic Issues Policy makers, health care professionals, educators, active community members, and social service practitioners have participated in the movement toward utilizing the school site as an accessible means of preventive health care service delivery. Components of a comprehensive school health program include not only health services but also psychological services and health education that can work toward preventing the behaviors that place teens at risk.

Although early sexual activity, unplanned pregnancies, and STDs have been recognized as interfering with a youth's ability to succeed academically, there remains controversy as to the extent public institutions, such as schools, should become involved. Issues that in particular trigger debate among parents and other community members are birth control, STDs, and homosexuality. Many individuals feel strongly that the school is not an appropriate place to discuss sexual activity and that parents have a responsibility and the right to educate their children about sexuality in accordance with the family's value system. Others hold the strong belief that society has a vested interest in preventing early pregnancy and sexually transmitted diseases and therefore must ensure that education of youth about such health concerns extends beyond the family. Controversies such as these can interfere, sometimes terminally, with efforts to educate or provide requested health treatment for adolescents.

Another strategy for discouraging early and/or risky sexual behavior has been to look at youth who are not engaging in such behaviors and to find out what factors contribute to their success in avoiding risk. These factors can then be considered when programs are developed. For example, teenagers who are goal-oriented have demonstrated less risky sexual behavior. A program in West Virginia has attempted to increase goal setting and to improve communication skills and problem-solving ability among their adolescents as a means to combat risk factors (Koprowitz 1999).

Substance Use

Incidence and Attitudes Substance abuse is one part of the cluster of negative behaviors that put adolescents at risk. It also directly contributes to risk, increasing probabilities of traffic accidents, difficulties in school, potentially dangerous sexual practices, and involvement in the juvenile justice system. Every year, the National Institute on Drug Abuse surveys high school students on their use of drugs, alcohol, and tobacco (Johnston et al. 2013). Students in 395 public and private schools anonymously self-reported their substance use patterns in 2012. This is one of the best sources of information about adolescent substance use and the source of the statistics used in this section.[1] Incidence is important in giving a sense of the scope of the problem. The trends may be predictive of the future and are a rough measure of the effect of education and prevention programs.

In 2012, use of alcohol continued a long-term downward trend and dropped to historic lows, with 3.6 percent of eighth graders, 14.5 percent of tenth graders, and 28.1 percent of twelfth graders reporting getting drunk in the past month. Percentages are much lower for daily alcohol use, at only 2.5 percent for twelfth graders. Despite this drop, alcohol remains the most commonly used substance among high school students, with 23 percent saying they have used it in the past year (Johnston et al. 2013).

Bruner and Fishman (1998) reviewed the literature to identify selected trends among adolescents in substance use and concluded that drug use among teenagers has risen since 1992. This trend continues, with 6.5 percent of eighth graders, 17.0 percent of tenth graders, and 22.9 percent of twelfth graders reporting use of marijuana. In 2011, 6.5 percent of twelfth graders used marijuana daily. Data from 1975 onward show that, as the perception that a drug is risky diminishes, use increases; this has happened in recent years with marijuana. Nonmedical use of prescription drugs is a significant part of teen drug use: 14.8 percent of twelfth graders used prescription drugs nonmedically in the past—a high number, but much lower than the 29.5 percent using alcohol or the 15.2 percent using marijuana in the past year. The use of drugs such as heroin, amphetamines, methamphetamines, and LSD has neither increased nor decreased in recent years. Tobacco, alcohol, and marijuana remain the most widely abused substances.

Despite being illegal, adolescents have easy access to drugs: responding to a survey, nearly

30 percent of high school students reported being offered a drug (usually marijuana) on school property in the year preceding the survey (Johnston et al. 2013). Alcohol also seems to be easily available, though adolescents cannot buy it directly; older friends and sometimes parents provide a supply. A study of 650 adolescents and their perceived risk to self and others relating to a range of topics, including drug/alcohol use and being in a car with someone under the influence of drugs or alcohol, was conducted over a four-year time span. Disturbingly, students rated drinking alcohol, drinking five or more alcoholic beverages on a single occasion, and using marijuana as less risky with increasing age (Smith and Rosenthal 1995). The link between substance use and involvement in the juvenile justice system is strong (Chassin 2008). With popularity and common use, it is difficult for adolescents to regulate their own consumption—"just say no" can be very hard.

Help for Substance-Using Youth Substance use, particularly heavy use, leads to poorer educational, occupational, and psychological outcomes (Chassin 2008). It is associated with risky sexual behaviors and with violence and accidents. Substance use impairs brain functioning at a time of life when learning is important and important decisions are being made.

There are many substance abuse treatment programs, and many models of treatment, and a great deal of research on the topic. Much treatment was developed in work with adults, and it is not certain how many elements transpose to adolescent treatment. Assessment is different: for adolescents, substance use may be experimental, occasional, binge-related, or chronic, and the setting within which the adolescent uses drugs affects the degree of risk (Fenster 2005). Many teens that have academic, behavioral, and emotional challenges are attracted to drugs or alcohol, and treatment must address these co-occurring problems (Reamer and Siegel 2008). And the risk-taking behavior that is part of adolescence feeds into enjoying the risk of illegal substance use.

Knowledge of treatment effectiveness is expanding rapidly in this, as in other areas of child welfare. Multiple studies exist, and overall the evidence concerning outpatient treatment suggests that any mode of treatment is better than no treatment. Completing treatment is linked with positive outcomes. Treatment models that are based on family therapy give some evidence of being the most effective (Tanner-Smith, Wilson, and Lipsey 2013).[2] Residential programs usually focus on underlying emotional or behavioral problems, and there is uncertainty about how well any gains in substance use transfer when the adolescent is back in the community. Drug courts with their use of authority to keep the teen in treatment have had some success with adolescents.

However, there are not enough programs to meet the demand, and the efficacy of programs is limited or unknown (U.S. Department of Health and Human Services 1999). Experts cite the need for continuing support after treatment if results are to be sustained, likening substance abuse to a chronic illness that needs long-term management (Chassin 2008). Given the interaction of substance abuse with schools, the mental health system, and the justice system, better coordination of educational and treatment efforts is needed.

Prevention is, of course, the cost-effective approach. If the community can be convinced that there is a problem, community action is a promising approach; note the success that Mothers Against Drunk Driving has had in turning an action once condoned into a serious offense. Drug education programs through the schools need to begin in early adolescence and need to be combined with supports to help the young adolescent master social and learning competencies.

Politics and economics can serve to define the problem, however. The drugs that receive community attention are subject to the climate of the community. Although alcohol is widely

regarded as teenagers' drug of choice, serves as a "gateway" to other drug use, and is the drug most associated with other risky behaviors (National Center on Addiction and Substance Abuse 1997), alcohol usually does not raise as much community alarm as do the illegal drugs. Koprowitz (1999) describes a substance abuse prevention program that the American Medical Association attempted to implement in a community where many people were employed by the local brewery. The effort was unsuccessful because community members were unwilling to identify alcohol as being an "abused substance." There is some speculation that campaigns to legalize marijuana have made it more acceptable in the community, and that this may be one factor in the rise in adolescent use of the drug.

Youth Without Family Support

A population of adolescents who have left their families or other caretakers and live independently of adult control and guidance has long been part of our society.[3] This independence is problematic because of the young age of the youth (and their abandonment of the traditional avenues of preparation for adult life) or because of the circumstances of leaving home. They are considered a vulnerable population (Osgood, Foster, and Courtney 2010).

Runaway and Thrownaway Youth Runaway youth are generally those who have left their homes or current places of residence without permission and have stayed away at least one night. Sometimes these are youth who have been excluded from their homes, usually by angry parents; these youth are often referred to as "thrownaway" youth. Sometimes they are youth who have left home voluntarily.

Homeless youth fall outside the service definitions of the child protective service system and the juvenile justice system. The Runaway and Homeless Youth Services Act, enacted in 1974, has been amended several times, most recently in 2011. It provides a structure for services to the older adolescents in this population, providing grants to fund street outreach, emergency shelters, and longer-term services for older youth including transitional living programs and maternity shelters. It also funds the National Runaway Switchboard (1-800-RUNAWAY), a national communication center used by both distressed youth and by parents.

Thirty-nine percent of the homeless population is adolescents, numbering approximately 1.7 million (Hammer, Finkelhor, and Sedlak 2002; National Coalition for the Homeless 2008). In 2012, there were 17,141 calls to the National Runaway Safeline call center—youth both out of their homes and calling the crisis line (National Runaway Safeline 2012). Seventy-one percent were endangered during the incident (Hammer, Finkelhor, and Sedlak 2002).

Studies of these youth indicate that they represent all socioeconomic, racial, and ethnic groups and types of families. Those who work with them think youth of color and those identifying as LGBT are overrepresented, but census estimates are uncertain on these dimensions. Two thirds are between ages 15 and 17. Many runaway episodes are short; an incidence study found most runaway/thrownaway youth to be gone less than a week (Hammer, Finkelhor, and Sedlak 2002).

Most have left home due to conflict with parents. Abuse is a problem for many. Hammer, Finkelhor, and Sedlak (2002) report that 21 percent of runaway youth have been physically or sexually abused in the year prior to their departure and are afraid of abuse if they return home; the National Coalition for the Homeless (2008) puts the figure at 46 percent. However, data from the National Runaway Switchboard in 2012 note that while 29 percent identify family dynamics as a precipitant of leaving home, only 10 percent indicate abuse (National Runaway Safeline 2012). Others have been ordered out of parental homes due to unacceptable behavior. Just under half of the homeless youth reported either being asked to leave by their parents or leaving with their

parent's knowledge but without their support (Greene et al. 1995).

Early surveys of this population found that a strikingly high proportion of these youths (20–35 percent) had been in the foster care system (Rothman 1991; Burt et al. 1999). This remains the common perception. The National Runaway Safeline, however, reported only 4 percent of the youth calling had been or were in foster care (National Runaway Safeline 2012). Further discussion of this group of adolescents and their particular needs is the critical issue of this chapter.

Homeless Youth Many of these youth who have left their homes do not find other shelter readily but become homeless for a time. Homeless youth are at greater risk for health problems, including STDs and AIDS; substance abuse; mental health problems, including suicide attempts; illegal behaviors, including prostitution; and other forms of victimization (Ringwalt et al. 1998; Halcon and Lifson 2004). One third of the youth living on the street reported haven been robbed, assaulted, or both. One half of those in shelters and two thirds of those on the street reported that they carry a weapon (Greene et al. 1995).

Street youth, because of their lack of schooling and marketable skills and the child labor laws, have a difficult time supporting themselves on the street. One concern is that these youth will be driven to risky behaviors for survival. Theft and drug dealing are among the activities to which they may turn. Youth also barter sex for money, shelter, and drugs. HIV rates for homeless young people are two to ten times higher than for other adolescents. More than a fifth of youth report having engaged in survival sex (Halcon and Lifson 2004). Thirteen percent of males, in a study comparing youth using shelters and those living on the street, report having gotten a girl pregnant (compared with 2 percent of males in a comparison group). One half of the females in the street sample reported having been pregnant at least once, and one tenth were pregnant at the time of interview (Greene et al. 1995).

In an excellent review, Staller (2005) notes the emphasis on the difficulties and poor outcomes for homeless youth. She suggests the need for more information on resilience and protective factors as services are framed for these youth. This theme is picked up in the final section of this chapter.

Service Needs Youth that have acted out their rejection of mainstream culture and of parental values constitute one of the most difficult populations to serve. They are also one of the most vulnerable populations. Programs for them need to meet immediate needs to ensure the safety of these youth and then ensure their access to education, employment training, health care, drug and alcohol treatment, and other social services. Shelters, transitional living programs, and daytime drop-in centers are all programs that provide central services from which to meet the needs of these youth. Outreach is an important part of shelter programming.

Shelters offer safe housing to homeless youth. They tend to be accessed by younger persons and, if funded through the Runaway and Homeless Youth Services Act, should focus their efforts on facilitating the return home for youth. The need for safe housing means an adequate number of shelter beds to allow for flexibility in length of stay, though shelters are designed to meet basic immediate needs during a short stay. Evaluation of the effectiveness of shelter programs has been scant, and results are mixed (Seisnick et al. 2009). Greene, Ringwalt, and Iachan (1997) found that 56 percent of youth sampled while living on the street had never used a youth shelter. About a third perceived them as dangerous, and a third thought of them as too restrictive. Almost two thirds thought shelter programs could be helpful, but they were wary.

Barriers to the use of shelters need analysis: it is probable that an emphasis on reuniting youth with their families and relatively short time limits on length of stay are disincentives

to youth who have run from a bad family situation. Additionally, the rules that a shelter must have to maintain a semblance of order may seem restrictive to youth who have come from neglectful and chaotic homes.

Drop-in centers are unstructured and meet immediate needs of street youth, such as food, clothing, showers, and laundry. Depending on funding, they might provide case management. A goal of these centers is to build trust with youth, so that the youth will be comfortable asking for further needed services. Extremely limited research suggests that drop-in centers offer short-term benefits to homeless youth; long-term benefits have not been studied (Siesnick et al. 2009).

Of the services available, homeless youth make the greatest use of health services, although the hospital emergency room was often their provider (Greene et al. 1995). Health care has been a service that youth drop-in centers have used to draw youth in. The health risks these young people face, the percentage pregnant or parenting, and their willingness to use health services make it imperative that health clinics be readily available.

Housing needs, particularly for older youth, include options for longer-term shelter, both residential housing and transitional housing. Access to ways of finishing secondary education, probably in a nontraditional way, gives these youth more opportunities. Links to employment options are necessary as youth become ready to begin the process of leaving the streets and assuming more conventional lifestyles. Independent living programs provide these resources to those who have been in foster care. Homeless youth and youth in independent living programs share many background experiences and current needs. The expansion of the federal funding for independent living programs, so that they could be offered to youth who do not qualify for Title IV-E foster care funding, will make the resources available to more youth who need them. This is, of course, another example of categorical funding limiting the capacity of developed services to meet needs of a larger group.

In all of these program settings, trained staff members and case managers should assess the needs of each individual youth and have the capacity to provide an array of services, including both individual and group counseling to attend to mental health needs, family therapy or other interventions for help if reconnecting with family is an option, training for employment, and independent living programs to assist in moving into adult living in a way that will bring them some stability, success, and rewards.[4]

There are ethical and value issues in working with these youth. An overarching issue is the question of the degree of self-determination that should be accorded. When a youth on the streets is engaging in high-risk behavior, how coercive should intervention be? Parental consent is an issue, as many of these youth are of an age where parental consent to medical procedures, drug treatment, and contraception may be required by law—yet these youth are in a place in their lives where they do not want parents involved. Confidentiality is usually promised to youth, as to other social work clients, but again high-risk behaviors of some youth make it difficult sometimes to decide when information should be shared, and with whom.

This is a difficult group of young people to serve. These youth are not actively seeking to make their living patterns more conventional. They are often suspicious of service providers, fearing that these providers will either attempt to send them back to their families or back into the child welfare system. They are difficult to engage in services. However, they can be engaged and can profit from the assistance in "bridging" back to mainstream society that is offered.

Youth with Extra Challenges

Very briefly, in this section we will look at three groups of youth for whom the transition to adult life is especially difficult. All three are groups

subject to bullying in schools and discrimination in employment and in the community. Each has struggled or is struggling to achieve equal opportunity, and each has achieved some success in seeing legal protections in place. The struggle for community acceptance and support continues.

Youth with Disabilities

Adolescents with disabilities face particularly difficult challenges. The term *disability* covers a wide range of conditions: disabilities include severe mental illness, cognitive impairment, autism, blindness and deafness, cerebral palsy, and multiple other conditions. For a generation, those with disabilities have struggled to have their competency recognized and to have the community see what, with necessary adaptations, they can do.

Adolescents with disabilities are perceived as "different" during a time of life when conformity is important, and they can feel that they are relegated to an inferior status. They are approaching the transition to adult life with many barriers to establishing a residence, obtaining employment, and forming lasting adult relationships. Their aspirations are similar to those of all youth, but it is harder to realize their dreams (Stewart et al. 2013). They need to engage in realistic planning about what they want for their adult lives and begin to take the steps that will lead them toward their goals. The families of these adolescents also face challenges as they come to terms with "letting go" of some of the protective practices and rewards of childhood years and turn to supporting youth in experimenting and discovering what they can do.

Prior to 1975, public schools were virtually closed to children with disabilities.[5] In 1975, basic rights to education were secured for children with disabilities when the Education for All Handicapped Children Act was enacted; in 1990, this was replaced by the Individuals with Disabilities Education Act (IDEA). Successive amendments have expanded the scope of IDEA, including provisions in the 2004 amendments that individual educational plans must include specification of needed transition services for each student age 16 or older. The goal of IDEA is to ensure that each student is provided with a "free and appropriate public education that prepares them for further education, employment, and independent living."

Progress toward this goal has been slow and steady. The accommodations mandated by the 1990 Americans with Disabilities Act gave visibility to aspirations to engage in community life. It changed community perception of the way in which those with disabilities wanted to participate in work and leisure activities and of their ability to participate. It has "improved the lives of the 50 million people with disabilities (half of them severely disabled) and served as a model for the rest of the world" (Hunt 2010).

For adolescents, this means that there is more emphasis on completing school, attaining the skills to find and keep employment, and establishing the relationships of their adult lives. In 2006, more than 6 million children received special education services through IDEA. As skills in delivering special education programs were developed and enhanced, youth began to make better use of this opportunity. A national longitudinal study found that, compared to 1985 (when the first wave of the study was conducted), in 2003 high school dropout rates had been reduced (Wagner et al. 2005). Forty-six percent of youth with disabilities who graduated from high school were reported to have enrolled in postsecondary schools. Youth with hearing and vision disabilities were the most participatory (Newman et al. 2010).

Finding and keeping a job is a goal of many youth with disabilities; this has been a more difficult goal to attain. In this respect, there was little change between 1985 and 2003; in 2003, 56 percent were employed for an average of thirty-eight hours per week (Newman et al. 2005). This is higher than the estimated overall employment rate for the disabled (50 percent)

and speaks well for the education and ambition of youth.

Rates of residential self-sufficiency, parenting, and marriage did not change markedly between 1985 and 2003 for youth with disabilities (Wagner et al. 2005). There has been very little study of this aspect of adolescence and transition.

The transition to adult life is extremely challenging for youth with disabilities. When asked to identify what they needed to navigate the transition successfully, youth tended to agree with professionals on the supports and services that they needed, but many reported that they had little access to these opportunities. Having paid employment in the field of their career interest was thought to be particularly valuable, but very few had this experience. Notable in its high ranking for importance among transition experiences was the concept of "learn how to set goals and stick up for myself." Family support was rated as extremely important by most youth (Powers et al. 2007).

A theme running through the literature on transition is the need felt by youth with disabilities (and all youth) to participate in planning and decision making. Paul Longmore (1995) suggests that the movement of disabled Americans, having achieved rights to education and equal access (at least for the most part), has moved to a second phase, a quest to redefine disability. It would abandon the medical model, which locates disability in the person and prescribes various treatments or therapies. Instead, a sociopolitical or minority group model of disability is offered: disability is different, not inferior. Disability status is becoming a civil rights issue rather than a social welfare policy issue.

Sexual Minority Youth

Despite rapidly changing attitudes, there is concern about the risk to which youth who are lesbian, gay, bisexual, or transgender (LGBT) may be exposed as they transition from adolescence to adult life. Recent years have seen social activism raising awareness of the issues of the LGBT community and attaining legal protections. Nevertheless, growing up in a society that offers them few role models or mentors, adolescents "step into their gay identity without the resources to provide a social context for growing up gay, loving in gay relationships, and developing resiliency in the face of homophobia" (Saltzburg 2005:212). We live in a society that is reluctant to acknowledge the issues of LGBT adolescents and reluctant to provide supportive services in school or community. Family support is critical to all adolescents in all of their developmental phases; families often have no idea how to react and how to support a child who "comes out." Emerging sexuality becomes a central issue in adolescent lives; the stress of recognizing difference, the absence of family, school, or peer supports, can lead adolescents into high-risk situations. Energies are channeled into finding an environment into which they can fit.

Because emerging sexual orientation is often hidden among many youth, there is no good estimate of the number of adolescents who will eventually identify as LGBT. Data from the National Longitudinal Study of Adolescent Health, a comprehensive study of adolescents in the United States, found that 7 percent of the study youth reported having had a same-sex romantic attraction or relationship (Russell and Joyner 2001). Most authors make no attempt to estimate numbers, noting only that because homosexual identity is hidden, numbers are probably greater than reported.

In their self-report study of 1,769 high school students in an upper-middle-class school district, Lock and Steiner (1999) found that 6 percent reported being gay, lesbian, or bisexual; 13 percent reported being unsure of their sexual orientation. Some of the stresses identified as contributing to the increased physical, emotional, and behavioral problems associated with sexual minority youth are (1) managing social intolerance; (2) physical injury experienced as a result of this intolerance; and (3) self-identification with negative opinions of

homosexuality (Lock and Steiner 1999:298). For youth whose families remain supportive, these stresses are easier to manage than they are for youth whose families abandon them.

Reflective of the difficulties of trying to fit into a society that does not acknowledge them, LGBT adolescents are vulnerable to depression and suicide. In multiple research studies, LGBT youth have been documented to have higher rates of suicide, up to three times the rate of heterosexual youth (Saltzburg 2005). These youth also experience increased health problems, higher rates of substance abuse, homelessness, family discord, sexual risk-taking behaviors, and school dropout (Proctor and Groze 1994; Lock and Steiner 1999). Services for runaway and homeless youth, with many LGBT youth among their clientele, have been more affirming of LGBT identity than have traditional child welfare services (Mallon and Woronoff 2006).

Families are critical for adolescents. Family rejection of an LGBT youth is associated with poor adolescent mental health, substance use, and sexual risk. Compared with LGBT youth whose families were supportive, one study found those from rejecting families were 8.4 times more likely to have attempted suicide, 5.9 times more likely to report high levels of depression, 3.4 times more likely to use illegal drugs, and 3.4 times more likely to report having engaged in unprotected sexual intercourse (Ryan et al. 2009). Parents need help in understanding the difficulties of LGBT youth, and work with families needs to be focused on keeping parents involved in the lives of their children (Saltzburg 2005).

LGBT youth have recently documented for us their experiences in the child welfare system (Mallon 1998). A sample of fifty-four self-identified gay and lesbian youth, living in three cities, were interviewed. Their stories are those of verbal and physical harassment in their own homes (from which they were often ejected), in foster homes, in group homes, and in the community. They searched for a "good fit." "When they found a responsive environment, they suspended the search and got on with their lives. Conversely, when and if they found themselves to be negotiating a life with a stress-filled, un-nurturing, and hostile environment, they either tried to adapt to that inhospitable environment or moved on to the next level"(Mallon 1998:119). Many had spent time on the streets as they searched.

The policy recommendations from this study are not those of more services or greater access to services, but those of changed services.

> A system designed to serve gay and lesbian youth must have . . . a historical and social perspective on sexual orientation as well as on race and ethnicity. The gay or lesbian young person must be the central focus of the system rather than the incidental or accidental recipient of services designed and operated for other people. (Mallon 1998:120)

The environment needs to affirm the LGBT identity and provide protection. This, the author points out, means recognizing the presence of LGBT youth, listening to their ideas, and re-educating to eradicate myths about LGBT identity. Additionally, it means recognizing the heterosexual orientation of existing child welfare organizations, bureaucracies, and staffs, and creating separate programs designed around the needs of LGBT youth.

Youth of Color

It is beyond the scope of this chapter to even attempt to explore the experiences of adolescent youth of color, the extent to which racism puts them at additional risk, and the protective strategies they adopt. To explore this, the reader is referred to the vast literature on diversity in the United States. A few notes will outline some major themes.

A disproportionate number of youth in the juvenile justice system are youth of color. They make up approximately two thirds of the youth in the juvenile justice system (Children's Defense Fund 2011). At every step of the process—arrest, detention,

incarceration—these youth are disadvantaged. African American youth compose 26 percent of youth arrests, 44 percent of youth detained after arrest, and 45 percent of youth committed to public facilities (Schiraldi, no date). The rate of residential placement for African American youth is about four times, American Indian youth three times, and Hispanic youth two times that of white youth.[6] African American youth, 17 percent of the youth population, make up 62 percent of the juveniles tried in adult courts and two thirds of those who are remanded to adult courts. No youth should be held in an adult prison, where their safety is at risk, and where programming is not appropriate for their age. However, two thirds of those tried in adult courts reside in adult facilities while awaiting trial (Children's Defense Fund 2011). Communities have in recent years developed initiatives to try to reduce this disproportionality, and some have had some success. Nevertheless, for a youth of color, particularly an African American adolescent, incidents that are relatively minor for a white teenager can morph into serious difficulties.

Violence is a serious problem for our society. As described in chapter 1, communities in which youth of color grow up can be poor and violent. Homicide is the second leading cause of death for young people ages 10–24 and the leading cause of death for African American adolescents. Most victims (86 percent) are male (Center for Disease Control and Prevention 2010). Most victims of juvenile violence are other juveniles, including children uninvolved in the conflict (Stephens 1997). African American youth are five times as likely to be victims gun violence as are white youth (Children's Defense Fund 2011). Safe communities are a primary service need for adolescents of color.

The evidence of limited services for children of color in the child welfare system has been presented throughout this book. The disproportionate numbers of African American youth in foster care suggests that a disproportionate number of those aging out of foster care without the support of families are African American. Thirty-eight percent of youth served in independent living programs are African American (U.S. Department of Health and Human Services 1999). This is a somewhat smaller percentage than one might expect, leading to the question, again, of whether these youth are receiving fewer services. The best count available of runaway and homeless youth documents that race is not a factor in this outcome: African American and Hispanic youth are roughly proportionate to their proportion in the youth population. Of course, it is possible that this is because African American adolescents have been swept into the juvenile justice system in disproportionate numbers.

Family support is important for all youth. Roberts (2002) writes of the disproportionate placement of African American children into the foster care system and the resultant destroying of family bonds. The justice system incarcerates differentially. Thus, parental support and advocacy for many of these adolescents is missing. Poverty, violent communities, family fragmentation—all are risk factors for adolescents of color.

Without exploring the needs of youth of color, it is not possible to comment extensively on service needs. However, the ideas concerning unique services, centered in knowledge of the history and experiences of particular peoples, which were put forth above in the discussion of services to LGBT youth, are worth serious evaluation. It is interesting to take these ideas a step further and recognize the success that African American, Hispanic, Asian, and Native American child welfare organizations have had in working with their own communities. Such organizations affirm the history and unique needs of a vulnerable people. Working within this framework, services are designed to meet these needs. The public policy question for child welfare is whether the development of such culture-specific organizations should be nurtured or whether this competence should be or can be incorporated into all child

welfare services—or whether both approaches are possible.

If we take the analysis of risk and the prediction of later difficulties seriously, we cannot help but realize that youngsters who grow up in communities beset by poverty, violence, and lack of opportunity are at risk. If we believe in prevention, targeting these communities for intensive intervention is a long-overdue initiative.

A Framework for Services

In the past section, we looked very briefly at the problems and problem behaviors of adolescents most commonly targeted for intervention by social services and the community. Policy considerations pertaining to remediation of these difficulties have been briefly examined. This section draws together four threads that run through the intervention ideas.

The first is the prevention of these adolescent difficulties. Early intervention programs, working with young children, have shown great promise in helping children learn to regulate behavior and respond positively to others in their environments. These programs were reviewed in chapter 4. Additionally, work with trauma has shown that provision of appropriate support at the time that a child is learning to cope with a traumatic event may prevent PTSD and thus assist the child and adolescent in modifying behavior to take advantage of opportunities. Investment in these early years can significantly reduce adolescent difficulties.

The second is that services to adolescents must be comprehensive and integrated so that they are readily available to adolescents in risk situations. This requires the development of procedures and structures that enable several service agencies to coordinate their responses in a helpful and holistic manner. Burt, Resnick, and Matheson (1992) identify the steps to integrating services, noting that the target population must be specified, goals must be clear, and a variety in breadth and depth of services must be offered in order to have comprehensive services. Beyond that, systems for delivery of services need to be identified (several models have been developed) and there must be administrative agreements to share resources. Pooled funding sources that can be used flexibly provide true service integration. The authors note the need for effective use of program evaluations. All of these steps seem almost self-evident, and all are very difficult to implement, requiring the adoption of new modes of thinking and the willingness of staff at all levels to think beyond traditional agency boundaries. Shared resources and pooled funding are perhaps the most difficult to accomplish in practice.

The third thread that emerges in all of the ideas for working with adolescents is that of individualized services, delivered within a framework of building on the strengths of the adolescent, and tailored to meet the individual needs of the adolescent. Most important, the services must be tailored to meet the needs of the adolescent as the adolescent perceives these needs, and to build on the strengths of the adolescent as he or she is ready to use those strengths. Independence is a critical component of adolescence. If an adolescent is to stay with a service provider, the provider must be ready to work at the adolescent's pace. This is the prescription for work with any individual, of course. The problem arises when the risk to which an adolescent is exposing himself or herself or to which he or she is exposing another is so great that intervention is necessary. At this point, the social worker will have to use all of the complex skills of the child protective service worker.

The fourth thread that emerges is the focus on community. Current research indicates that if risk antecedents could be modified, adolescent problem behaviors would be lessened. This speaks first, of course, to intervention in poor and violent communities, at many levels, to increase safety and to increase opportunity. It speaks to the provision of the family support services outlined in chapter 4. But examination

of these adolescent problem behaviors also suggests that changes in community attitudes and community willingness to target problems and devote resources to solutions can have important impact. Social work turned its back on the community as a target of intervention after the 1960s. It seems to be turning back.

Critical Issue: Facilitating the Transition from Child Welfare Services to Adult Living

In September 2011, there were 400,540 children in foster care in the United States (U.S. Department of Health and Human Services 2012). Approximately 26 percent of these children were 15 years of age or older. While most youth return to their families (U.S. Department of Health and Human Services 2012; Wulczyn and Brunner-Hislop 2001), a significant number of young people remain in foster care until adulthood and "age out" of child welfare services. Between 20,000 and 30,000 young people are emancipated from child welfare services each year in the United States (U.S. Department of Health and Human Services 2012) when they become too old to continue receiving foster care services. The age of majority varies from state to state but is typically 18 to 21 (Avery and Freundlich 2009; Courtney 2009).

The transition from child welfare services to independence is often abrupt for foster youth. Payments for foster care maintenance cease, and while some youth maintain relationships with foster parents or continue to live with them, many young people must make their own living arrangements. Caseworker support, including connections to a host of services that have supported youth emotionally, mentally, and physically during their time in foster care, also ends for most youth at this time. The abbreviated transition to independence is very different from the gradual transition to adulthood that has become common for many young adults, as described earlier in this chapter, and it is little wonder that foster youth have exhibited difficulties in making this transition.

Policy Responses to the Transition Outcomes of Foster Youth

Beginning in the 1980s, older adolescents in foster placement began to receive attention due to the difficulties associated with their experiences in care: high numbers of transitions, a lack of permanency, and the lack of preparation for a successful transition to adulthood (Aldgate, Maluccio, and Reeves 1989; Courtney 2009). The lack of preparation for a successful transition to adulthood became apparent in the few studies that attempted to document the early adult lives of young people who had experienced foster care placement. In early adulthood, former foster youth had lower levels of educational attainment. Former foster youth were less likely to complete high school or attend college than their peers in the general population and were more likely to experience unemployment, earn lower wages, experience housing instability, and require public assistance (Zimmerman 1982; Festinger 1983; Jones and Moses 1984). While former foster youth in these studies reported some levels of social support, reporting contact with members of their birth or biological families and foster families, it was clear that child welfare services were not addressing the needs of young people in the transition out of foster care. Policy responses to the troubling outcomes of young people leaving foster care have resulted in several amendments to Title IV of the Social Security Act.

The Independent Living Initiative of 1985 (Public Law 99-272) was the first piece of legislation aimed specifically at those adolescents who would reach adulthood and emancipate from foster placement (Collins 2004; Courtney 2009). The Independent Living Initiative created independent living programs, which were designed to provide foster youth with the necessary skills to live on their own as adults. Under these newly created programs, young people ages 16 to 18 received instruction in daily living skills, case

management, and education and employment support. Independent living programs were initially allowed to provide transitional planning for youth but were prohibited from providing financial assistance with housing.

Funding for independent living programs rose to $70 million and became permanent in 1993. It was divided into two categories: $45 million was available to states without any matching funds, and $25 million was available to states with a dollar-to-dollar state match. Funding remained at that level, though the number of youths leaving foster care increased. Youths who were age 16 and over, and for whom foster care payments were being made, were eligible for independent living programs. Thus, California and New York, the states with the largest populations of children in foster care, spent the most for independent living programs (U.S. Department of Health and Human Services 1999). Other federal programs provide some assistance to this population, such as Transitional Living Services for Homeless Youth and Job Corps, which enrolls economically disadvantaged youths in need of education or training. Independent living programs are, however, the only federal program targeted at helping adolescents make the transition from foster care to adult living.

Funding for independent living programs expanded once again in December 1999, when President Clinton signed into law a bill, the Chafee Foster Care Independence Act, that doubled the Title IV-E Independent Living Program from $70 million to $140 million and allowed states to extend Medicaid coverage for young people until they are age 21. The outcome measures states are required to implement include education, employment status, avoidance of dependency on public welfare, homelessness, nonmarital childbirth, high-risk behaviors, and incarceration.

The process that resulted in the expansion of independent living programs, as reported by Boyle (2000), involved advocacy by youths themselves; professional organizations prepared to provide data, share meaningful experiences, arrange visits, and present ideas to senators and representatives and their staffs; and a series of circumstances that brought independent living programs into the national spotlight. Early in the process, in 1997, a group of young people who had been in foster care had the opportunity to talk with Hillary Clinton as part of a recognition ceremony for passage of the Adoption and Safe Families Act:

> "They told me about being forced out of their homes on their birthdays, about staying in a cold dorm room alone during the holidays because they had nowhere to go, about getting sick and having no insurance to get any medical care." Particularly striking to her was a young woman who said, "You know, it's almost Thanksgiving and I have no one to call and ask how to bake a turkey." (Boyle 2000:52)

It was a bill that appealed to almost everyone. Democrats saw it as promoting positive youth development, and Republicans saw it as promoting self-sufficiency. The major opponents of the bill were, interestingly, those who were lobbying for increased resources for adoption under the new provisions of the Adoption and Safe Families Act (ASFA) and feared that expansion of independent living programs would be viewed as an indicator that older adolescents should not be adopted.

Independent Living Programs

Independent living programs have served an increasing number of youths in the twenty-five years of their existence; although with funds remaining fixed, the amount spent on each youth has declined. In a 1999 survey, surprisingly, it was found that half the youths served had been in foster care less than two years before reaching 18 years of age. Not surprisingly, about one quarter of those served were described as having special needs, and 9 percent either were parents or were pregnant (U.S. Department of Health and Human Services 1999). More recent demographic data do not seem to be available.

Most independent living programs offer education and employment assistance, providing tutoring and remedial work to help participants graduate from high school or receive a GED; many of the programs offer aid for college or vocational training. Difficulties exist in developing appropriate employment opportunities to teach skills and appropriate work habits, and funding limits the ability to provide needed vocational training. Almost all programs offer training in daily living skills and report that these skills are best developed through experiential learning. The programs also report the benefits of teaching interpersonal skills such as conflict management, communication, and decision making. There is a demand for transitional living arrangements, supported by services to help youths deal with issues that arise, but transitional living facilities are limited, serving only a fraction of the young people who could benefit from them (U.S. Government Accountability Office 1999).

A 2001 amendment to the Foster Care Independence Act provided the funds to create Educational Training Vouchers (ETVs). ETVs provide up to $5,000 each year for youth leaving care to cover expenses associated with the cost of education and are available to youth until age 23. Most recently, the Fostering Connections Act of 2008 allowed states the option to extend foster care placement for youth up to age 21 provided youth are completing high school, engaged in postsecondary education, employed or participating in a training program that supports employment goals, or in need of care due to a medical condition (Courtney 2009). Extended independent youth housing, group care, and kinship care are also provided under the Fostering Connections Act.

The Transition from Foster Care

What do we know about the transition out of foster care? Over the past few decades, many scholars have taken notice of the difficulties youth face in the transition from care to adulthood. While much work has been done, two studies that are commonly cited by scholars and advocates offer a detailed description of young people leaving care using large, representative samples: the Midwest Evaluation of the Adult Functioning of Former Foster Youth (Midwest study), which followed the transitions of youth from three Midwestern states (Illinois, Iowa, and Wisconsin) (Courtney et al. 2007), and the Northwest Foster Care Alumni Study (Northwest alumni study), which involved case record reviews and interviews with young adults who had been placed in private or public foster care programs in Oregon and Washington state between 1988 and 1998 (Pecora et al. 2006). Each study offers different strengths in terms of documenting the transition to adulthood.

The Midwest study was undertaken in part to evaluate the effectiveness of the 1999 Chafee Foster Care Independence Act. All youth involved in the Midwest study entered foster care prior to their 16th birthday, and their primary reason for placement was abuse and/or neglect. Follow-up interviews have been conducted with youth at age 19, 21, and 23 to 24, and most recently when these young people were between the ages of 25 and 26 (Courtney et al. 2011). Youths leaving care were asked the same questions as adolescents in the National Longitudinal Study of Adolescent Health (Add Health), a study surveying health behavior among a nationally representative sample of 12,118 young people (Resnick et al. 1997). This allowed the authors of the Midwest study to draw comparisons between the health of young people leaving care and other young people in the general population. In addition, because youth in Illinois were allowed to remain in foster care until age 21, the study has allowed for comparisons between young people who emancipate from care at age 18 and those who have the option to continue accessing support through child welfare services into early adulthood. While the study leaves many aspects of young peoples' lives that may affect their transition to adulthood unexplored (such as the age of entry into care and the length of time spent in care), a major strength of the study is its

prospective nature, which has allowed researchers to understand youths' transitions as they are occurring, and its longitudinal design, ideal for investigating a transition that is by nature an extended process.

While the Midwest study allowed the documentation of the process of the transition from child welfare services to adulthood and demonstrated the relative benefits of extending care, the Northwest alumni study allowed researchers to document the long-term economic and educational outcomes for young adults who had been placed in foster care (Pecora et al. 2006). In addition, because the Northwest alumni study was exploring the experiences of young people who had been in public child welfare in two states and in the private Casey Family Programs in both states, it allowed researchers to make comparisons between different types of services and investigate which aspects of the foster care experience (for example, placement characteristics, education, therapeutic services, foster family activities, and preparation for leaving care) support young people in the transition to adulthood. The Northwest alumni study uses comparison data from the general population, primarily census data, to compare the outcomes for former foster youth to those for other young adults (Pecora et al. 2010).

As mentioned above, both studies offer their respective strengths and limitations, but both have been widely influential and are cited often by advocacy groups focused on enhancing the transition to adulthood for young people who reach the age of majority while receiving foster care services and find they are no longer eligible for support. Both studies converge on a picture of a transition to adulthood that is difficult for large numbers of young people leaving foster care.

Significance of the Difficulties Faced by Youth in the Transition to Adulthood

Research literature[7] highlights the difficulties faced by young people in the transition from foster care to adulthood. While most of these studies draw from recent work that explores the experiences of youth transitioning with the benefit of independent living programs and the changes to policy aimed at ameliorating difficulties in transition, a few older studies that document long-term trends, particularly in educational attainment, are also included.

Housing Several studies have documented the high rates of homelessness, with all the risks outlined earlier in the chapter, among youth leaving care. Follow-up interviews with youth twelve to eighteen months after their discharge from child welfare services in two separate studies have found that 14 percent had experienced at least one night of homelessness since leaving care (Courtney et al. 2001; Courtney and Dworsky 2006). In comparison, approximately 7 percent of the general population will experience homelessness in its lifetime (Kushel et al. 2007). Young adults in the Northwest alumni study reported higher rates of homelessness within their first year after leaving foster care, with 22.2 percent reporting experiencing at least one night of homelessness in the year after their discharge from care (Pecora et al. 2006). The proportion of former foster youth who had experienced housing instability (moving frequently, housing costs that exceeded 50 percent of their income, or having difficulties affording housing) at one year postdischarge was much larger (39.4 percent; Kushel et al. 2007).

The risks or homelessness are vivid in the memories of young people transitioning from foster care.

> J. had been on his own for three years after running from a foster placement at age 17. He described his transition to adulthood without preparation or employment. "Right away there were challenges: no money, no job, no school . . . with no food, no money, no place to go—I had to figure it out real quick. . . . I was on my own night and day, trying to figure out what I was going to eat, where I was going to wash my clothes, where I would work, and watching out for myself at night, you know, staying safe."

M. was eighteen years old and aware of the difficulties many young people face in the transition out of foster care. While M. had some contact with his birth family, he had spent the majority of his life in foster care and had been in so many placements he couldn't recall the names of all of the people who had cared for him. M. reported that the statistics about foster youth weren't "true" for everyone, and shared his plans for job training. However, M. also shared his fears about homelessness: "I have worries about being homeless . . . that's one of my greatest fears . . . I don't want to be on the streets."

Employment and Financial Stability Among 19-year-olds surveyed in the Midwest study, 40 percent were currently employed (Courtney and Dworsky 2006). Earnings of these current and former youth were low, with 75 percent earning less than $5,000 annually and 90 percent earning less than $10,000. Because of their low earnings, foster youth and former foster youth were twice as likely as their non-foster peers to lack the necessary money to pay rent and four times as likely to experience eviction (Courtney and Dworsky 2006).

For many former foster youth, financial instability may extend throughout young adulthood. Among young adults in the Northwest alumni study (ages 20–33), the employment rate was 80 percent (for comparison, the employment rate among young adults in the general population is markedly higher at 95 percent; Pecora et al. 2006). Given the higher rates of unemployment, it is not surprising that these young adults were also five times more likely than members of the general population to be receiving public assistance through Temporary Aid to Needy Families and were three times more likely to live in poverty than others in the general population.

The young man in the following example notes that his difficulties in finding employment extend beyond education, job training, and the job market:

M. shared that being away from family placements during his adolescence had impacted his ability to find employment. ". . . your parents are the ones that teach you all that stuff, and I haven't had the chance to learn that because I've been in group homes for most of my teen years when I would have learned that stuff." M. hoped that job training programs would help him to learn the skills he was missing, and noted that an absence of practical skills such as driving would also impact his ability to find work and support himself in the transition.

Health Comparisons between the general health of 17- to 18-year-olds in foster care in Illinois and youth in the general population yield some similarities. For example, more than three quarters of youth in the foster care sample and the Add Health sample reported that their general health was "good," "very good," or "excellent" (Courtney, Terao, and Bost 2004). Foster youth were more likely to access health care than their counterparts in the national sample, including physical exams within the past year (86.1 percent compared to 80 percent) and dental exams (74.3 percent compared to 66.7 percent). Foster youth were also more likely to use psychological or emotional counseling (35.9 percent compared to 13.9 percent).

In terms of sexual health, foster youth were much more likely to get tested or treated for an STD than young people in the Add Health sample (23.9 percent compared to 6 percent; Courtney, Terao, and Bost 2004). Among young women, foster youth were also much more likely to report a pregnancy (32.6 percent compared to 18.9 percent) and less likely to report that the pregnancy was desired (68 percent reporting "definitely or probably not" desired in comparison to 56 percent). Foster youth were much more likely than their peers to have given birth (51.7 percent compared to 20 percent) and four times less likely to have received an abortion than their peers in the Add Health sample (9 percent compared to 36 percent). However, among pregnant and/or parenting young people, foster youth were much more likely to receive prenatal or

postnatal care than their peers in the general population (16.6 percent compared to 4.7 percent).

Substance Use Pilowsky and Wu (2006) used a nationally representative data set of young people aged 12–17 and found that teens with any lifetime experience of foster care were five times more likely than other adolescents to have had a drug dependence diagnosis within the past twelve months. A study comparing the substance use of adolescents in foster homes to youth living with their families found that foster youth had higher rates of cigarette, alcohol, and drug use than their at-home peers (Backović et al. 2006). While foster youth used alcohol at rates only slightly higher than those of their non-foster counterparts, they were often initiated to alcohol and cannabis at significantly younger ages.

Education Relatively large numbers of foster youth transition out of care without completing a high school diploma. Nearly 35 percent of young adults interviewed by Festinger (1983) had not completed high school prior to leaving foster care in 1975. More recently, follow-up interviews conducted with youth leaving foster care in the Midwest study found that at age 19, 37 percent of these youth had not completed a high school diploma or General Equivalency Degree (GED; Courtney and Dworsky 2006). Among slightly older young adults in the Northwest alumni study, former foster youth showed rates of high school completion similar to those of members of the general population (84.8 percent, nearly the same as the 87.3 percent among all young adults; Pecora et al. 2006). However, it is important to note that these alumni were much more likely to hold a GED than members of the general population (28.5 percent compared to 5 percent).

Rates of high school completion among foster youth vary significantly from those of their peers who did not experience foster care placement, as shown in Blome's (1997) comparison of youth in foster care and a matched sample of youth who lived with at least one parent: 63 percent of the youth in foster care graduated on time compared to 84 percent of their peers who were not in foster care. A similar pattern was noted among 19-year-olds in the Midwest study, with 63.9 percent of former foster youth holding a high school diploma or GED compared to 90.6 percent of their peers in the general population (Courtney and Dworsky 2006).

It comes as little surprise that lower rates of high school completion are followed by lower rates of participation in postsecondary education as well. Thirty-nine percent of the young adults in the Midwest study were enrolled in postsecondary education at age 19 compared to 59 percent of their peers in the general population (Courtney and Dworsky 2006). The Northwest alumni study, looking at educational outcomes for young adults into their early thirties, found that disparities persist in young adulthood. While 42.7 percent of alumni received some postsecondary education, only 20.6 percent received a vocational or technical degree, and among older alumni (ages 25–33), the rate of bachelor's completion, 2.7 percent, was much smaller than the rate among similar-aged members of the general population (24.4 percent; Pecora et al. 2006).

The impact of early abandonment of education is described, and lamented, by the youth in this interview:

> J. reflected on the experience of being placed in foster care abruptly following a loss in his family at age 15. He was moved from the neighborhood he'd grown up in to a new neighborhood and lost his connection to school as well as his extended family. After a series of moves from foster home to foster home, J. left care at age 17. Running from foster care impacted his ability to finish school, and three years later J. lamented the barriers he would have to overcome to finish his high school diploma and felt that college was little more than a dream. "What I would tell myself if I could go

back, knowing what I know now . . . get your education, go to school. I wish I would have graduated."

Disconnection Young people who are neither enrolled in school nor employed in the workforce raise concerns about disconnection among scholars. Among young people aged 16–19 in the general population in 2006, the rate of "disconnection" is 9 percent (Annie E. Casey Foundation 2006). While disconnection among all young people is cause for concern, young people in the transition from foster care were much more likely to be disconnected. The Midwest study revealed that in 2006 at age 19, 46 percent of males and 41 percent of females were "disconnected" (defined as neither working nor enrolled in school). At age 21, levels of disconnectedness decreased to 40 percent and 31 percent, respectively. In comparison with peers in the general population, former foster youth were often more likely to be disconnected from places of employment or education. One quarter of former foster youth were enrolled in schooling at age 21 compared to 46 percent of their peers in the general population (Courtney et al. 2007). And while foster youth reported similar levels of having ever held a job as those of young people in the general population, they were less likely to report being currently employed than their peers in the Add Health sample (53.4 percent compared to 63.9 percent).

The authors also included parenting as a marker of connectedness, which had a larger impact on the proportion of young women who were connected, making the proportion of those who were considered disconnected 23 percent at age 19 and 12 percent at age 21. While it is likely that parenting may have served to connect some young people, it is also likely that parenting served to further distance some young people from ties to potential supports gained through education and employment.

Studies investigating the transition from foster care to adulthood demonstrate the high level of need among young people leaving care, but it is likely that these studies underestimate the impact of disability on the transition out of foster care. Definitions of disability are often unclear, but special education status is commonly used as a proxy for disability, and estimated rates of special education service are high among foster youth, typically 30–40 percent (Geenen et al. 2007). Because youth with developmental disabilities (Courtney, Terao, and Bost 2004) and youth with severe disabilities (Pecora et al. 2010) were excluded from these larger studies, it is likely that the transition experiences of youth in foster care with serious disabilities are not reflected in these data. While less is known about the transition experiences of young people in care with disabilities, the data suggest that they experience even greater difficulties in the transition to adulthood in terms of economic, educational, health, and housing outcomes (Geenen et al. 2007; Hill 2009).

Diversity of Experiences in the Transition Out of Foster Care

At this point, it is useful to pause and consider the fuller picture. The foregoing summary of outcomes is put forth to illustrate the high level of need among youth in the transition from foster care to independence, but it obscures the broad range of experiences and responses to transition among foster youth (Pecora et al. 2006; Stein 2006; Keller, Cusick, and Courtney 2007). Rather than painting all foster youth in the transition to adulthood as part of one monolithic group of struggling young people, several scholars have worked to document the differences among foster youth. Stein (2006) suggested that young people leaving care fell into three groups: those who "move on" and do well in the transition to adulthood; young people who are "survivors," who draw support from personal and professional relationships and exhibit resilience; and "victims," who experience many disadvantages and require extended support throughout the transition to adulthood.

Identifying different patterns of transition experiences among foster youth does more

than explore the diversity among youth; it also helps with matching services to youth based on their needs. Keller, Cusick, and Courtney (2007) used baseline data from the Midwest study to assess different levels of preparedness for the transition to adulthood. Examining educational and employment history, parenthood, placement type and stability, problem behavior, and runaway history, four patterns among youth were identified:

1. *Distressed and disconnected* young people seemed likely to experience the most difficult outcomes in the transition to adulthood, based on placement history and incidence of nonfamily (group setting) placements, runaway history, higher rates of victimization, higher levels of educational needs, and problem behaviors. Youth who appeared distressed and disconnected composed the largest proportion of the sample, at 43 percent. Males and females were equally likely to be represented within this group.
2. The next largest proportion of the sample (38 percent), in contrast, was dubbed *competent and connected*. Youth in this group tended to have fewer placement changes, were frequently placed with kin, and were more likely to report close, supportive relationships with others. These youth tended to do well in school and had work experience as well. Youth in this group were more likely to be female, and a high proportion of these youth were African American.
3. *Struggling but staying* youth faced challenges in school and high rates of special education placements and behaviors that led to expulsion or incarceration, but also tended to ask for and participate in intensive services. This description fit a smaller proportion, approximately 14 percent of the sample. While young people in this group seemed to present a host of challenging behaviors, they had no reported history of running and were more likely to ask for help from child welfare services. The majority of these young people were male.
4. A fourth group constituted a small percentage of the sample (less than 5 percent), which reported high levels of grade retention in school, limited employment histories, and higher rates of parenthood. However, these youth tended to have experienced only one placement, and most of these placements were with relatives. These youth also reported strong levels of connection to their neighborhoods and high levels of social support. Males and females were represented equally within this group, and African American youth made up the majority of this subgroup.

These data provide some useful insights into the group of young people transitioning to adulthood. First, the descriptions attempt to capture some of the depth of these youth as people: most of the youth described exhibit both strengths and challenges in the transition to adulthood. Second, the study poses some questions regarding the juxtaposition of these strengths and challenges in the lives of young people. For example, young people in the third group tended to exhibit higher rates of "problem behaviors" (incarceration and expulsion), but they were also more likely to ask for help from child welfare services and exhibited a remarkable absence of running from placements, which may suggest that they are willing to work with current caregivers and may be able to overcome many of the difficulties of transition.

The authors note several caveats in interpreting the data: within each "class" of youth, there is much intraclass heterogeneity. The results suggest patterns and trends but should not be viewed as predictive of young people's experiences or futures. While this analysis provides a detailed look at patterns of preparedness for transition among youth and provides some guidance in selecting the types of services that will be most useful to young people in transition, there are many questions remaining. In observing the data and the trends that emerge among young people, one wonders to

what extent these trends are due to experiences preceding foster care and/or experiences that occur during foster care. Have these patterns persisted into young adulthood? For youth who appear disconnected and distressed (the largest subgroup), *why* are they disconnected from others? What supports might be useful for youth navigating the transition, even with a host of obstacles (grade retention, lower educational attainment, little to no employment history, "early" parenthood, and a history of nonfamilial placements)?

Current Independent Living Programs

Before pursuing potential questions about what types of supports might be beneficial to young people leaving care, it is important to review what is known about the impact of current efforts to support youth in transition. To date, reviews of the effectiveness of independent living programs are sparse. A systematic review of the literature assessing the effectiveness of independent living programs revealed mixed results, with most participants in independent living programs reporting some gains in educational attainment, employment, and housing (Montgomery, Donkoh, and Underhill 2006). However, the authors note the lack of randomization and control groups, small sample sizes, differences between youth in independent living programs and comparison groups at baseline, and the widely varying formats that independent living programs can take. Furthermore, use of independent living services is low among foster youth in transition, with less than half (44 percent) of all eligible youth accessing independent living services, with great variance from state to state. Some states served as few as 10 percent and others served 100 percent of eligible youth (U.S. Government Accountability Office 2004). An earlier review of states' reports on independent living services revealed the challenges in bridging instruction with application in youths' lives (U.S. Government Accountability Office 1999). While most states offered training to support education and employment, few states were able to support youth in the application of these skills in the workplace (for example, apprenticeships or on-the-job mentoring). In a similar vein, classes in daily living skills were offered widely, but youths had fewer opportunities for experiential learning. And while most states offered some support for transitional living, the scarcity of this resource meant that only a fraction of the current and former foster youth were being served in transitional living arrangements.

Social Support and Foster Youth in the Transition from Care

The majority of research on the transition from care has focused on educational, economic, and health indicators that indicate self-sufficiency. This emphasis on economic independence and self-sufficiency has shaped interventions, which are largely focused on economic independence. For example, independent living programs have traditionally focused on training tied to physical and economic independence, rather than the more difficult to measure cultivation of relationships with others (Samuels and Pryce 2008). In this section, we will review findings examining foster youths' connections to support networks during the transition out of care.

Connections of Foster Youth A common misconception about foster youth is that they are youth "without families," but many studies reveal the variety of connections that youth draw support from. Collins, Spencer, and Ward (2010) surveyed ninety-six former foster youth and found that most reported connections to supportive adults in a variety of roles, with a high number of the relationships initiated through contact with the foster care system (caseworkers, independent living program outreach workers). The authors noted that these relationships were helpful with short-term outcomes, such as securing a living space. An evaluation of a mentoring program aimed at supporting youth in the transition out of foster care matched youth with program advocates in

long-term (two years or more) relationships, finding that relationships of longer duration allowed mentors to provide critical support to youth in the form of daily living skills training and practice (Osterling and Hines 2006). Foster youth also draw support from informal mentoring relationships. Studies of foster youth have found large proportions of these youth identifying a natural mentor, through relationships established informally (family, friends, neighborhood) or through formal pathways such as child welfare, school, or the mental health system (Munson and McMillen 2008). Exploratory in-depth interviews with a small group of female foster youth of color who identified relationships with "natural mentors"[8] revealed that these relationships were trust-based and resembled parent-child relationships, providing emotional, informational, and instrumental support, as well as the sharing of someone else's perspective (Greeson and Bowen 2008). And the literature is fairly consistent in the high amount of continuing connections foster youth report to family (Festinger 1983; Keller, Cusick, and Courtney 2007; Courtney et al. 2007; Collins, Paris, and Ward 2008). Former foster youth who reported connections to family (biological parents, siblings, or foster family) tended to experience fewer difficulties in the transition to adulthood than youth who did not report these relationships (Kerman, Wildfire, and Barth 2002). Increasingly, child welfare services have shifted toward maintaining connections to family. One example is the Family Finders model, a program that has been in use since 2000 to locate family members of children and youth in out-of-home placement and engage those relatives in planning and decision-making regarding permanency plans for young people in care (Pecora et al. 2009). Untangling the effects of family relationships upon youth in care is complex. For example, the young people described in the fourth group of the Midwest study by Keller, Cusick, and Courtney (2007) exhibited multiple barriers to the transition to adulthood but were the most likely to report being "very close" or "somewhat close" to at least one relative.

However, others caution about the potential for harm in emphasizing relationships as a support for youth in transition. In a review of mentoring literature, Spencer and colleagues (2010) highlight the importance of duration, frequency of contact, and emotional connection in maintaining mentoring relationships that promote healthy outcomes for young people. There is a negative impact for youth whose mentoring relationships end early (Grossman and Rhodes 2002). The mentoring of foster youth needs to be approached thoughtfully, as mentors may face significant challenges in establishing relationships with foster youth (Britner et al. 2006). Analyzing interviews with former foster youth, Samuels and Pryce (2008) identified traits they collectively termed as "survivalist self-reliance" among young people, noting that this self-reliance served as both a measure of resilience and a risk factor for youth, as youth reported reluctance to draw emotional support from others.

Mike Stein (2006) lamented the lack of theoretically driven research on the transition out of foster care, suggesting that attachment theory, focal theory, and resilience provided useful frameworks for the interpretation of the growing body of literature on youth transitioning out of child welfare services. The holistic life course perspective is identified as the theoretical background in a study by Samuels and Pryce (2008), and Munson and McMillen (2008) draw from relational-cultural theory, but few studies that have examined the relationships of youth in transition have an identified theoretical background. Because of the multifaceted nature of support one can draw from relationships with others, social capital is, in the next section, explored as a potential lens for the interpretation of data describing the transition out of foster care.

Social Capital Theory and the Transition from Foster Care The term *social capital* refers to the actual or potential resources available to

an individual arising from that individual's membership in a group (Bourdieu 1986). In other words, the reciprocal exchanges between members of a network function as a means of building social capital (Coleman 1988), with the amount of social capital one can draw on varying based on network size and the amount of economic, cultural, or symbolic capital held by members of the network. Bourdieu argues that social capital may be especially salient during periods of transition. The importance of social capital during transitions suggests that the understanding of social capital held by foster youth may be critical to helping youth navigate a transition that has traditionally been difficult. For example, the third group of foster youth described by Keller, Cusick, and Courtney (2007), who were "struggling but staying," reported that they were satisfied with their care experience and were likely to ask social workers for help. While this group exhibited struggles, such as higher levels of special education placement, the ability to draw on the social capital in relationships may buffer their transition and support resilience.

Coleman (1988) argues further for the importance of social capital in creating human capital through educational attainment. Family, according to Coleman, is critical in building social capital: the presence of family members and the strength of the relationships between family members function to build social capital that influences the educational outcomes of young people. Coleman also notes the importance of extra familial factors on building social capital for young people, such as the relationships between family members and community institutions. Perhaps most salient for a discussion of foster youth and social capital is Coleman's discussion of the impacts of frequent moves and school changes, which interrupt the process of building social capital. Blome (1997) found that foster youth were twice as likely as their non-fostered peers to have changed schools three times during middle and high school. Among young adults who had experienced foster care surveyed in the Northwest Foster Care Alumni Study, nearly one third had experienced ten or more school changes throughout their educational career (Pecora et al. 2006).

Challenges to Maintaining Social Capital in Foster Care and the Transition While not all child welfare involvement includes out-of-home placement, foster placement is almost always at its core disruptive to social networks. Perry (2006) explored the disruption of support networks among foster youth during placement, noting that youth in her sample experienced an average of 4.11 different placements and reported diminished support from biological family in particular. While some youth were able to form new ties and draw support (from foster family members and peers), youth who experienced high levels of network disruption also exhibited high levels of psychological distress.

It is also likely that policy responses to the troubles noted in the transition from care may have inadvertently discouraged youth from cultivating relationships with others from whom they might draw support during the transition. Traditionally, independence has been put forth as a reasonable goal for young people who reached the age of majority while in foster care and could no longer receive services. However, many (Propp, Ortega, and Newheart 2003; Samuels and Pryce 2008; Avery and Freundlich 2009; Courtney 2009) have questioned whether independence is a realistic goal for young people leaving foster care. Interdependence, rather than independence, is a more realistic goal and more closely resembles the daily living of most adults, who draw support from a network of formal and informal connections. Few among us can truly be called "self-sufficient." The Fostering Connections Act of 2008 represents a significant shift in policy approaches to support young people as they transition from child welfare services to adulthood; even in its naming, the legislation de-centers independence as an immediate goal

of transition and denotes the importance of connections in early adulthood (Courtney 2009). As demonstrated by the Midwest study, young people who spend a longer time in foster care (remaining in care until age 21 rather than 18) were more likely to remain enrolled in an educational program and experienced fewer economic hardships (Courtney and Dworsky 2006). It may be that extending care until age 21 allows young people the time to build these connections with members of their biological, birth, and foster families, as well as work with other service providers involved in their transition.

However, as Courtney (2009) notes, the Fostering Connections Act was passed into law with many more stipulations for young people than existed in its original drafting, reflecting the concern among some lawmakers that extending support would promote continued dependence among foster youth. In addition, the law's provision of matching federal funds for states that opt to extend care for foster youth past their 18th birthday means that states must choose to extend care and provide the other half of the funding for extending foster care services. In the current economic climate, programs serving young people who are often perceived as capable of independence are at risk of being cut in favor of services for citizens who are seen as more vulnerable (box 9.1).

BOX 9.1

Youth Advocacy and Public Policy: February 2009

It's a cold winter morning in the Pacific Northwest, and hundreds of young people in foster care from across the state are huddled in a large tent on the state capitol grounds. These youth have gathered to share their stories with lawmakers in support of the passage of five bills, including one that would allow some youth to remain in foster care beyond age 18. Before leaving the tent to meet with legislators, the youth are addressed by the governor's budgetary assistant, who reminds youth of the precarious financial situation that the state is in and the multibillion-dollar shortfall legislators are facing.

"We've got to take care of our most vulnerable citizens," she tells the crowd. "Older people and the very young. Everyone else is going to have to face some cuts, I'm afraid."

A young woman in the crowd responds to this, "Help us now or help us later!" With other youth around her nodding and the visitor at the podium listening, she continues. "Help us now or we will become your most vulnerable citizens. Help us now or we will become the people you support in drug treatment, or in homeless shelters, or in prison. Help us now so we don't become those vulnerable people!" For nearly thirty seconds the noise inside the large tent is overwhelming, as youth and their advocates clap and cheer in support.

Youths' testimonies throughout the day led enough lawmakers to listen and to vote for the passage of five bills. Several of the bills had an important but limited impact, continuing funding for existing independent youth housing, extending foster care to age 21 for some youth, and supporting some youth through tuition support. Two provided support for all foster youth, allowing foster youth the right to legal representation in court and the right to visit siblings.

However, each year brings the possibility that programs supporting foster youth will be found on the list of cost-saving cuts.

Conclusion

Literature detailing the transition from foster care to adulthood describes the difficulties faced by young people: financial struggles, lower levels of education, and high rates of homelessness and housing instability. While concerns about the impact of foster care are nothing new,[9] it is only fairly recently that attention has been paid to the transition of young people from foster care to adulthood and to policy that addresses this transition. Independent living programs provide some assistance to foster youth in transition, but little is known about their effectiveness, and the majority of youth eligible for these programs do not receive services.

Scholars and advocates have raised concerns about the appropriateness of independence as a goal for foster youth in young adulthood. Prior

to the passage of the Fostering Connections Act of 2008, independence was the assumed goal for young people who were leaving foster care settings, most commonly at age 18. The Fostering Connections Act provides steps toward the dismantling of independence as a goal for young people in care, a goal that has been shown to be difficult for many youth to attain and ultimately detrimental to the lives of young people in transition.

Many questions remain. How should support be provided to young people, particularly young people who have engaged in extended services within a variety of settings (mental health and educational settings are two that come to mind) and may be weary of more "help"? Extending foster care support is not necessarily the answer, but sufficient evidence exists that also discredits the current approach of removing supports completely when youth reach a certain birthday. Because so many youth remain in contact with their families of origin, it is important to ask how these families can be better engaged in child welfare services during the time that their children are in care. How can child welfare services help these families remain a presence in their children's lives, particularly as so many young people will return to their families after foster care placement ends? But foster youth, often by virtue of foster placement, need supports beyond their families. How can the connections that foster youth have to important people be supported to build the social capital that so many of us draw from every day in our own transitions to adulthood?

Final Thoughts

The themes of this chapter lead to recognition of the complexity of adolescent life and decision making in our current society. To develop programs that will assist youth in navigating these years, we need clarity about our expectations for youth in society, and a determination to move toward enhancing the opportunity structure of all youth. In adolescence, the emotional and behavior problems that had their roots in childhood exposure to poor and violent communities and families without the resources to nurture their children become acute and hamper growth. Neglect and abuse in childhood are associated with academic problems, conduct issues, and mental health difficulties in adolescence. Increasingly, we are aware of the degree to which behavior is shaped by both this past and by the world in which the adolescent must live. Social capital, opportunity ladders, and participation are necessary if the youth are to seek and achieve skills that contribute to society. Given the employment market into which they will move, education emerges as a critical rung of the opportunity ladder.

Youth attempting this transition from out-of-home care face all the difficulties of the transition, but without the support of a family to advise and encourage and to return to when difficulties become overwhelming. Having assumed responsibility for the care of an adolescent, the child welfare system also has responsibility for providing support during the transition. Independent living programs are a start. However, we need to know much more about what elements of these programs are most useful and to expand their availability as well as the array of supports offered.

Adverse childhood experiences, poverty, impoverished family life, discrimination, absence of role models that embody success rather than failure—all are barriers to success. Young people must be shown opportunities for success in civic participation if they are to overcome these barriers. Intervention in communities, support to families, and recognition of how essential it is that youth have the opportunity to develop and use their strengths should provide the policy base for the next decade. Because such a strategy is the route to social justice, it becomes the great adventure of social planning and striving in our day.

NOTES

1. Note that the survey takes place in schools, thus not including those adolescents who have left school—a group progressing less steadily toward adult life. Inclusion of these teens would probably raise the numbers reporting substance use.
2. The rapid expansion of evidence-based practice is noted by the author of this meta-analysis, who notes that there are studies under way, at the time her article was written, that met the criteria for inclusion. These criteria are similar to those described in chapter 5 in the discussion of evidence-based practice.
3. As described in chapter 6, Brace's rescue of New York's street children was part of the development of foster care.
4. Federal funding for programming to teach skills needed for employment and independent living and to provide money for living costs while a youth completes school or a training program is primarily available through the John H. Chafee Foster Care Independence Program and is available only to youth who have graduated from the foster care system.
5. For the story of one mother's struggle to get education for an autistic son, the reader is referred to Barbara Roberts *Up the Capitol Steps* (Corvallis, OR: Oregon State University Press, 2011). When her son was refused a public school education, she began her political career as a member of the local school board. Barbara Roberts became governor of the state of Oregon in 1991, but that is another story.
6. An excellent and disturbing look at the situation of youth in residential facilities in the corrections system is presented in *No Place for Children: Voices from Juvenile Detention* by Steve Liss (Austin: University of Texas Press, 2005). Quotes from youth, probation officers, others in the justice system, and many, many photographs make up the book.
7. Case examples in this section were drawn from ethnographic research conducted in a community program working with young people anticipating and experiencing the transition out of foster care (Cunningham and Diversi 2013). This research was completed through the Department of Human Development at Washington State University Vancouver and involved interviews with case managers and participant observation, as well as in-depth interviews with youth themselves. The youths' stories serve as the primary source of data for these case examples, and where appropriate their direct words are included.
8. The authors defined *natural mentors* as an important adult, other than a parent, that had a significant influence on the youth or could be counted on in a time of need.
9. See, for example, VanTheis (1924), Baylor and Monachesi (1939), Meier (1965), or Festinger (1983).

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10

Concluding Thoughts

Who has seen the wind?
Neither you nor I:
But when the trees bow down their heads
The wind is passing by.

—Christina Rossetti

The past decade has been a time of change in child welfare practice. After a time of focus on safety for children and a time of focus on finding permanent homes, a "perfect storm" of research has led the field back to its beginnings, when child welfare meant attending to the well-being of children. The components of the storm:

- The Adverse Childhood Experiences Study (ACES), documenting the long-lasting effects of adverse childhood experiences.
- Brain-imaging technology that has shown us the physical manifestations of childhood adverse experiences.
- A recognition of the frequency of trauma and its impact on children, and techniques to help children overcome trauma.
- Development of practice models that have an empirically based foundation and are thus known to be successful.
- Longitudinal studies documenting the impact of events over time in many areas of child welfare practice, the National Survey of Child and Adolescent Well-Being (NSCAW) attempt to document the "whole" of child welfare practice, and the use of large data sets to compare children in the child welfare system with children leading more usual lives.
- Reinvigoration of the long-held goal of prevention, both primary prevention, through enhancing community supports to families, and effective early intervention to mitigate the long-term impact of those adverse events that do occur.
- Several programs initiated by the federal government to encourage states to prioritize well-being; these include legislative mandates to include well-being in case plans,[1] training opportunities and Title IV-E waivers to encourage states to develop programs to incorporate well-being into planning, service delivery, and evaluation, and the Child and Family Services Review (CFSR). The CFSR actually monitors and helps states shape service delivery, pushing new knowledge to the front line of practice and holding states accountable for implementation. The data from NSCAW are providing indicators of whether changes in service delivery are taking place.

As the reader will have surmised from reading the historical background pieces scattered throughout this text, of the elements of this "perfect storm," only the brain-imaging technology and the capacity to gain information from large data sets are completely new. The other components have been in child welfare for a long time, sometimes with different labels. The literature of child welfare is replete with the recognition of the long-term impact of abuse, neglect, poverty, and other childhood adversities, and with discussion of the trauma of family

violence and dysfunction and of separation and placement. The expanded research base has brought these elements to the fore.

Of these elements, the one that has had a direct effect on children and families and on the child welfare workforce is the implementation of the CFSR. The reviews, described in chapter 2, are the mechanism through which the Children's Bureau attempts to assist public agencies in enhancing their service delivery. The reviews are closely linked to the outcome measures of safety, permanency, and well-being, and include assessment of the delivery of services. The principles guiding the reviews are those of family-centered practice, strengthening parents' capacity to provide for their children's needs, individualizing services to children and families, and collaboration of child welfare and voluntary community-based services.[2] Case records and interviews with caseworkers, families, and community partners provide data for the reviews. The reviews evaluate each state's performance, and the reporting of outcome measures focuses on improvement in services. The purpose is to "promote an agenda of change and improvement in services to children and families nationally" (Milner, Mitchell, and Hornsby 2005). New knowledge leads to the development of new policy, but until that policy is actually adopted by practitioners, its impact is limited. It is the old saying, "What matters is where the rubber meets the road." In this chapter, we will focus on that intersection.

Well-being, the focus of the CFSR, is defined by the federal government as meeting children's developmental needs in physical health, cognitive development, emotional/behavioral development, and social development (U.S. Department of Health and Human Services 2012b). The focus thus shifts to the quality of care, at home or in out-of-home care, with nurturing and guidance and provision of services such that well-being is secured. Safety and permanency, earlier goals of the child welfare system, are part of well-being, but not the whole.

In this chapter, we will revisit a few of the major themes of child welfare policy and attempt to connect them with the elements of this new direction. We will look at some indicators of the success of this new child welfare. We will examine the "fit" of social work and child welfare, which is much closer within this new paradigm. And we will, in the last section of the chapter, focus on the education and retention of the child welfare workforce—that critical workforce that actually translates the research and policy into attitudes and actions.

Integrating New Ideas and Existing Practice

Increasing Focus on Continuity of Care

Though safety remains a core need of children, there has been a growing recognition of the importance of the continuity of relationships as a child grows. It is this interaction with a trusted caretaker that buffers a child from the impact of adverse events and helps a child overcome trauma. This has led both to an increasingly strong push for permanency for children, to greater hesitation in making any placement into out-of-home care, and to an emphasis on continuity in out-of-home care. There are 27 percent fewer children in foster care now than there were in 1998. The length of stay in foster care has decreased from a median of 20.5 months, almost two years, in 1998 to a median of 13.4 months, just a bit over a year (U.S. Department of Health and Human Services 2013). The guidelines for visits by parents to children in foster care are more generous than in the past, and NSCAW data report that 60 percent of children see their parents twice a month or more (U.S. Department of Health and Human Services 2003). Continuity of care is preserved for many of those who do not return home: 53 percent are adopted by their foster parents and 33 percent by relatives (U.S. Department of Health and Human Services 2013). These are impressive changes and show a growing focus on continuity of care through preserving family ties. However, placement stability for long

out-of-home placements has not improved—a difficulty that needs more study to identify the characteristics of these children, their placement trajectories, and how the programs that have demonstrated success in preventing disruptions are accomplishing this.

However, these changes are not sufficient. Data from ACES and from NSCAW have shown that early childhood adverse experiences are common, and neurologic studies emphasize the serious impact they have on future social and emotional development. This is important for child welfare services, for NACSW also shows that children entering the child welfare system experience a far higher number of traumatic events than that reported by the general population, with older children having more adverse experiences[3] (Stambaugh et al. 2013). These youngsters are very likely to have their cognitive and social/emotional development compromised and to present behavioral difficulties.

Services Tailored to Meet Children's Needs

There is a new recognition that all children entering the child welfare system need to have a careful developmental assessment. Services, including mental health services, must be shaped to meet needs that are identified. NSCAW data indicate that the assessment of children's status at entry to the child welfare system is taking place.[4] One sees the variability among the states in the range of referrals to meet these needs, from 5.1 percent to 68.5 percent. The meaning of this is not clear, however, as a common reason for not making a referral was that the service was already being received. Among children referred, almost all received services.

As often noted, one problem with services in child welfare has been the system's inability to tailor services to meet individual needs, and the lack of resources to meet basic needs of families. Engagement of families in services is increasingly recognized as a critical dimension of service effectiveness; engagement is developed through families having a say in the planning of services and through the provision of needed concrete services (money for gas, food, diapers, and so forth) prior to engagement in educational or psychological services. Aside from the development of community-based family preservation programs, there has been little movement yet toward child welfare agencies forming the partnerships and shared funding streams necessary to accomplish this. Child welfare has also been notable for mandating that all families receive parent training and counseling, regardless of the specific needs of the family. NSCAW data indicate that services are being appropriately targeted, so perhaps this is changing (Dolan et al. 2012). Whether these services are sufficient and effective we will learn as the NSCAW study continues to track the children's development.

Protective Services

There is evidence of a different attitude toward the troubled families that are accused of abusing or neglecting their children and come to protective services. From the policy makers comes the idea that these are families that want the best for their children and might be adequate parents if they receive sufficient support; that they do not have to be ordered by the court to engage in services, but will do so voluntarily if services are provided; that voluntary social agencies, churches, and other community groups can be involved in the care of troubled families; and that protective service cases should look more like the example of the boy on the roof in chapter 3, rather than like the baby placed from the hospital in chapter 6.

Expectations for protective services are high. In chapter 3, the difficulties of the protective services system were reviewed. We noted the great amount of worker time spent investigating complaints that were not substantiated, and the shockingly small percentage of those families involved in abuse or neglect who received appropriate services. Data from the NSCAW will be important in monitoring this more closely.

Child welfare's involvement with the court has resulted in a pattern of caseworkers prescribing services and expecting clients to comply. This is not a pattern that encourages family engagement in services. Note the use of the word *mandated*, frequently used in describing services that the court has ordered. Both that word and its corollary *compliance* need to vanish from the language of child welfare service delivery.

The development of alternative response systems may change these service delivery patterns markedly. In chapter 3, alternative response systems were described. These reflect a more collaborative interaction with the family and a greater attempt to mobilize community services to support the home. A steadily increasing number of states are developing alternative response systems; currently, more than half of the states use these systems. The children served through alternative response, as a group, resemble children determined to be nonvictims after a traditional investigation; in other words, a low-risk group. As experience with these response systems develops, more difficult family situations will probably be included. To date, safety does not seem to be compromised by this mode of response (Child Welfare Information Gateway 2008; Kyte, Trocme, and Chamberland 2013).

Foster Care

Foster care has been overwhelmed with an increasing number of children who need placement while, as we saw in chapter 6, demographic changes have reduced the number of foster homes, and the complexity of parents' problems has lengthened children's stays in foster care. This may be changing. The number of foster care placements has dropped precipitously. Use of alternative response protocols, efforts to preserve families and avoid foster placements for children, and the increasing use of kinship foster care may have begun to solve the problem of capacity. Fewer children in foster care and better foster care are the dual goals.

It is important that foster parents receive the training and support that they need if they are to be successful in caring for the troubled children who come to them. If the number of foster home placements continues to decrease and if workers become increasingly aware of the trauma that re-placement causes, this support may increase. The impact of the CFSRs can be seen in the increase in the percentages of children whose caseworkers see them monthly, from 46 percent in 2008 to 82 percent in 2011; most of these visits were in the home where the child was living. This increased support is not, however, reflected in placement stability. Placement stability during the first year in foster care is fairly good, but states struggle with stability as placements grow longer, with a little less than a third of the children in foster care two years or longer having two or fewer placement settings. There is no change over time evident in these data (U.S. Department of Health and Human Services 2012a).

Frequent contact with a worker has been identified by foster parents as an important support: if this increased contact is not affecting placement stability, one wonders if workers are implementing the most effective ways to support foster parents. There is relatively little information on this topic, other than demonstrations of very intensive training and support in therapeutic foster care. Given the problems that children are bringing with them as they enter foster care, it is an area ready for development.

Permanency Planning

The information about permanency is more solid. In 2011, permanency with a family was achieved for 86 percent of the children who left foster care: the states were less successful in moving children with disabilities, with only 76 percent achieving permanency. Child welfare services take a long time, particularly from the perspective of a child's life; only a third of adoptions took place within two years of a child's entry into care. However, returns home were timelier, with two thirds of the children who returned home doing so within a year

(U.S. Department of Health and Human Services 2012a).

Return Home Return home is not always permanent. Of the children who entered foster care in 2011, 13.2 percent were entering within twelve months of a prior episode (U.S. Department of Health and Human Services 2012b). Inadequate services, particularly a lack of post-return services, or inappropriate services may be a factor in this rate of return to foster care, as discussed in chapter 6. It is also possible that the use of permanency as an outcome measure puts pressure on workers to return children to their homes when the homes are not ready. Implementation of the Adoption and Safe Families Act (ASFA) may have increased this tendency.

Most children are back home within 18 months of referral.[5] The NSCAW data give us a glimpse of the services that these families may need after a child returns home. According to their caseworkers, the needs of caregivers with whom the child is living (either returned home or never placed) were most frequently financial assistance (42.9 percent) and mental health services (39.2 percent). The major needs of caregivers for children who were involved in reunification efforts were substance use services (64.8 percent) and mental health services (64 percent) (Dolan et al. 2012). These are categories of service delivered by partners of the child welfare system and they are not always available. They also reflect chronic need. These services are both preventive and remedial; the limited data available suggest that community development, a realm of social work expertise, may be badly needed.

Adoption Under ASFA, adoption became an important means to the goal of a permanent home that would provide care that would emphasize the well-being of the child. The Multiethnic Placement Act removed racial matching from the adoption placement process. Parents' rights were not to be protected unless they demonstrated a commitment to creating a caring home for their children. As we saw in chapter 2, the initial impact of ASFA has been the movement of many children out of foster care and into permanent adoptive homes.

The CFSR has focused on moving children who are ready for adoptions into permanent adoptive homes quickly. This "remains a challenge" for most states. There is considerable variability among states, with most states showing some improvement in some aspects of moving children toward adoption. A study of the procedures behind the success of a few states in moving children quickly into adoption would be worthwhile (U.S. Department of Health and Human Services 2012a).

Prevention

Community conditions are to some extent also the responsibility of the child welfare system. Historically, advocacy has been a role of social workers and child welfare workers. Ken Watson (1992), a social worker and a leader in child welfare, once noted that agencies have six responsibilities: "leadership and vision, planning and coordination, standard setting and licensing, training, funding, and the provision of some direct service" (p. 10). With the new knowledge provided by ACES and the new brain-imaging technology, prevention of maltreatment is increasingly promoted as part of the work of the child welfare system.

Advocating in the Community In the preceding chapters, nine issues were identified as critical to the well-being of the children and families being served by the child welfare system, and received in depth examination as the "critical issue" of the chapter. Some, such as poverty and racism, are outside the parameters of a system defined as child protection but fall well within the scope of a system defined as promoting child well-being. Some, such as early childhood education, assume increasing importance as new knowledge about brain development and the consequences of poor experiences emerges.

There are, of course, additional issues critical to child welfare and to the families that receive

services. The reader might well have chosen different "critical issues." One additional important issue is substance abuse—both its impact on children and families, and the question of how policies can be crafted to protect children's well-being and allow parents the time necessary for recovery simultaneously. The way in which our society provides mental health services and the ways in which the child welfare and mental health services systems interact are important because many of the children who enter the child welfare system have extensive mental health needs, as do their parents. Education emerges as an important issue for children in the child welfare system: poverty and poor schools, disruptions due to placements and re-placements, stress—all make achievement difficult. Space limitations have prevented deeper exploration of these and many other larger social issues that are critical to child welfare, but it is important to remember that they are part of the context of child welfare services.

The Impact of Poverty One out of five children in the United States lives in a household with income below the poverty line; a third of our children are poor. Among children of color, the percentage is much higher. Poverty is associated with many difficulties in raising children and with poor outcomes, as we saw in chapter 1. Though maltreatment crosses all socioeconomic boundaries, the association between poverty and child maltreatment is so strong that poverty is bound to be one of the chief concerns of child welfare professionals.

It is possible to eradicate poverty; it was almost accomplished in the 1960s during the War on Poverty. Great strides were made then in reducing child poverty. Now, however, these gains have been lost. The elderly fared better; their poverty was alleviated through the indexing of Social Security benefits to the Consumer Price Index; those gains have been maintained. Such a universal approach has never been tried in this country for children. Perhaps the elderly are of greater concern; they vote, and almost all of us will become elderly one day.

For many years, families with dependent children were guaranteed a basic minimum monthly amount to live on. It did not lift them out of poverty, but it provided some security. As discussed in chapter 2, the welfare reform of the 1990s put its focus on helping heads of families find employment. With a mix of job training, subsidies for child care, and time limits, the reform has been quite successful in reducing the numbers who rely on "welfare" payments. However, families are no longer entitled to basic income support.

It is difficult to think about implementing the goals of protecting children, preserving families, and maximizing child development without this basic support. The goal of the worker who administers Temporary Assistance to Needy Families (TANF)—to get the parent into full employment—will often conflict with the goal of the child welfare worker to enable the parent to provide adequate child care. Child welfare agencies will have to be very careful that children are not being placed in out-of-home care for reasons of poverty.

Child welfare workers are in a key position to see the impact of child poverty and to make that impact known. As social work with its historic interest in poverty reenters the child welfare arena, perhaps poverty and income maintenance will become key concerns of the child welfare system, rather than worrisome issues that belong to another system.

Early Childhood Education The quality of care in early childhood is critical to future development. This is the time of the greatest plasticity of the brain. The brain-imaging studies have added to our knowledge of the importance of early childhood experiences. These studies have made success in the prevention of child abuse and neglect all the more urgent. But in addition to this goal, it is important to meet the basic developmental needs of young children. Early childhood education was identified

in chapter 4 as one of the critical issues of the welfare of children, and indeed it is. This is where early difficulties can be discovered and where remedial work can begin.

Affordable, high-quality child care is a need of families at all income levels. Quality child care can be delivered only by well-trained and adequately reimbursed personnel. Overall, as chapter 4 illustrated, it is an expensive service for families. Lower-cost, subsidized programs such as Head Start often have long waiting lists. Most of the cost of providing early education is in the teachers who will interact with these children; the low level of their pay should be a concern for child welfare.

The current initiatives to provide universal pre-kindergarten programs are an important step toward the goal of seeing that all children are prepared to succeed in school and in life. Perhaps this is the realm of child development in which it is most evident that early deficits compound with time. It is outside the realm of child welfare services and service reviews, but well within the realm that child welfare advocates should be monitoring.

Prevention Prevention is difficult to assess, for one is measuring something that did not happen. One can, however, mark the increase in programs that have been proved effective in intervening to abort various behaviors that impede positive development. A new and exciting development is the presence of an increasing number of these programs that have been evaluated with rigorous methodology and have proved effective. Among them are the Nurse-Family Partnership and Healthy Families America for families with very young children (discussed in chapter 4) or the Incredible Years parent training or the Positive Parenting Program for parents with somewhat older children (also discussed in chapter 4). Most used with adolescent populations, multisystemic therapy and multidimensional foster care were introduced in chapter 7, and there are others. These programs share an emphasis on creating a consistent environment and rewarding positive behavior.

Next Steps

All of this wonderful new data has provided a great deal of information about the child welfare system and the progress being made to encompass children's well-being as a goal. It has also shown us places where progress has been minimal and where our efforts need to be directed.

Youth Entering the Child Welfare System as Adolescents About a quarter of the children who enter the child welfare system are age 12 and over (U.S. Department of Health and Human Services 2013). Most of our conceptualization of child welfare services focuses on younger children. We need to know more about the reason that these youth enter the system, about services needed and provided, about how many of them are discharged to permanent homes, how many use independent living services, and how they fare as young adults. With this information, a model of services can be developed and tested.

We know that adolescents in the child welfare system are often severely troubled. Like the youth in chapter 8, they may have entered the system because of behavioral/emotional problems that need specialized placements and treatment. Or they may have had a long history in foster care, which usually means many different placements. It is thought that many have mental health diagnoses, are dependent on psychotropic medications, and have serious educational deficits. CFSR data note that states struggle and have had little success in finding permanent homes for these youth, and they are more likely to reenter foster care after a return home than are younger children (U.S. Department of Health and Human Services 2012a). The studies of adjustment of youth who have graduated from foster care (chapter 9) demonstrate that we have not found a way to meet the needs of this population.

Disproportionate Representation of Children and Families of Color Amid all the indicators of change and progress that we have noted, the experiences of children and families of color remain a serious concern in child welfare services. The percentage of children of color in foster care, a major indicator, has changed less than one would hope; in 1998, 65 percent of children in foster care were children of color, as were 56 percent in 2012. There was great variability among the states in 2011 in this disproportionality, ranging from one and a half to three times the state's population of children of color; there were no states in which a disproportionately large number of white children entered foster care. The disproportionality remains greatest for African American and Native American children.

Throughout our study of child welfare, we have seen indicators that families of color received fewer services than white families. As we saw in chapter 3, their children are more likely to be placed in out-of-home care, and once in care the children are less likely to receive services. They remain in care longer than white children. A troubling statistic emerges in the data showing a larger proportion of white families receiving an alternative response to a child abuse report—once again, it appears that families of color may not be receiving all available services.

Implementation of Changes

For most of the 1970s, workers focused on the discovery of ways to keep the newly discovered abused and neglected children safe. Reflecting concern about long stays in foster care, for most of the 1980s and 1990s, agencies demonstrated their success and measured the job performance of their workers by measuring the achievement of permanency—return home or adoption for children. Now another dimension has been added—the quality of care a child receives to ensure well-being. Attempts to include children's well-being in worker responsibilities may meet with reluctance to take on this added dimension unless new resources become available. Whether the process of the CFSR and the penalties attached are sufficient to obtain new resources and worker buy-in remains to be seen.

Some child welfare practitioners are worried about the inclusion of measures of child well-being as an outcome. Barth (2000) found child welfare agency managers to be concerned that "measuring affective, cognitive, and physical well-being . . . would create the expectation that child welfare services were intended to promote optimum development (rather than just prevent the increasing trauma of repeated abuse)" (pp. 764–65). The author, however, supports such measurement, arguing that the involvement of the agency indicates significant risk to the child and represents an investment of public resources; both the risk and the investment warrant follow-up evaluation.

If we are to achieve the ultimate outcome of children and youth who grow into productive members of our society, the field must, as Barth contends, turn its attention to child well-being. Unless children are well cared for as they grow, this outcome will not be achieved. A major research and policy issue in the next decade is going to be the development of measures of child and adolescent well-being, which will serve as markers to indicate whether children are progressing along the path of positive development.[6]

Social Work and Child Welfare: The Nature of the "Fit"

Assumptions

Social workers begin with the assumption that parents are doing their best and that they have strengths on which better lives can be built. This outlook makes it difficult for social workers to adopt approaches that throw families immediately into adversarial systems. This assumption underlies the philosophy of differential response systems, and the proliferation of those systems may make child welfare more compatible with social work practice. Training

that teaches the uniqueness and value of each individual makes social workers most comfortable working within systems that enable them to engage families in cooperative work.

Social workers believe (based on considerable evidence) that children grow best in their own families. It is not that social workers believe that children necessarily belong to their families; children are individuals with rights, not possessions. But they recognize that children suffer when separated from their homes, however distressed those homes may be; and they are familiar with a body of child development research that emphasizes the importance of sustained attachment to a single caregiver. Social workers are also realists and are skilled at assessment. If children are unsafe, if families cannot mobilize to make changes, if family and community supports are lacking, social workers move children to safe homes, using their knowledge of child development to minimize the trauma.

Social workers thrive on engagement and joint problem solving. They dislike, and are not trained for, confrontation. The court system, as it currently functions, is uncomfortable for social workers. They are unsure of their role and sometimes angered by confrontational lawyers who do not seem to recognize their professional knowledge. The supervision of the court often seems to the worker to be an expression of the court's distrust of social workers' judgment and actions. The court's mandating of services and asking for compliance with its orders introduces a language foreign to social work's attempt to engage clients in mutual problem solving. An understanding of legal procedure helps but does not wholly eradicate the feeling. Thus, for the social worker, the child welfare agency's partnership with the courts is more difficult than those with other community service systems.

Values and Ethics

The *Code of Ethics* of the National Association of Social Workers lays a sound value base that undergirds child welfare practice and provides guidance in many situations. The code is, however, akin to policy. It lays down general guidelines but does not resolve specific issues.

> Specific application of the Code must take into account the context in which it is being considered and the possibility of conflicts among the Code's values. . . . Ethical decision making is a process. There are many instances in social work where simple answers are not available to resolve complex ethical issues. Social workers should take into consideration all the values, principles, and standards in this Code that are relevant to any situation in which ethical judgment is warranted. Social workers' decisions and actions should be consistent with the spirit as well as the letter of this Code. (National Association of Social Workers 1996)

Pine (1987:319–23) suggested a working model for thinking about ethical dilemmas in child welfare, a model that is as valid today as when it was developed. To solve a dilemma, the child welfare worker answers the following questions:

1. What are the conflicting values?
2. From what aspect of the social intervention—policy, target group, implementation, or outcome—do the major issues arise?
3. What are the practitioner's duties or obligations in this case? From what sources do they arise? Are they conflicting?
4. What are the uncertainties or unknowns? How can they be diminished?
5. What are the sources of power? Is the distribution of power equal? What can be done to equalize it?
6. Have the parties voluntarily consented to or participated in the choice of alternatives? Do they have the information and capacity to consent?
7. What are the needs and rights of each party—the right to freedom, privacy, well-being, protection from harm? Are these

rights in conflict with one another? Which rights have priority?
8. What is the nature of the limited resources available to support this intervention? On what basis will their distribution be justified?
9. To what extent are there ethical conflicts among the various professions involved in this case? How are they in conflict?

Pine's seventh point might well be the first. The common phrase "the best interests of the child" prioritizes the rights and needs of the child. But these cannot be protected without the involvement of others. Over and over, the varied perspectives of those involved in any protective service case highlight this issue. The court with its legal proceedings safeguards the rights of everyone, but the adversarial procedures complicate mutual engagement in problem resolution.

Pine's fifth question is particularly relevant to child welfare services. In many instances, the distribution of power is not equal. The fear of having children removed pushes parents toward agreeing with worker demands; yes, they will engage voluntarily in community services to improve the safety of their children—but is it really voluntary? The fear of never seeing their children again pushes parents into mediation—yes, they will voluntarily agree to give up their rights as parents in exchange for some type of open adoption for their child—but is it voluntary? These are troubling questions.

The sixth point, the informed consent of the client—to research, to treatment, to any intervention—is also critical, and is an aspect often lost in the culture of child welfare. To that might be added the ethical responsibility of the social worker to be in possession of the best available information—to keep up with the literature, to know the empirical foundations of interventions, to know the current issues of the community. Thus, the quality of information shared with clients will make this consent truly informed.

The *Code of Ethics* is very specific about social workers' responsibility for social justice. Education for practice encompasses principles of self-determination, the uniqueness of the individual, and the empowerment of people to make decisions about their own lives. In broader terms, social workers are educated to be concerned about any group of people that do not enjoy equal opportunity in society. Signs of discrimination in the child welfare system, are thus of particular concern to social workers in the field.

Social workers can also influence child welfare practice so that it is shaped to empower the poor and those perceived as "lower class." In classic works, Costin, Karger, and Stoesz (1996) and Swift (1995) have written about how class consciousness and a patriarchal society can shape child welfare practice, and Pelton (1989) and Lindsey (1994) focus on the impact of poverty. The interaction of race, class, and poverty with entry rates, service provision, and outcome variables in child welfare practice must be examined on a multisystemic level to weed out biases and inequalities and to develop promising practice and policy solutions, and the educational background of a social worker creates a good basis for this examination and weeding.

Advocacy

Social workers are advocates. Advocacy is the tradition of social work. It is among the social worker's ethical responsibilities, rooted in their responsibility to promote social and economic justice, and it is a part of their education. Advocacy has been variously defined in recent years. A good definition of advocacy includes education, social action, influencing public policy, and intervention on behalf of clients (Downs et al. 2000:466). The Children's Defense Fund, referenced frequently throughout this volume, is probably the major advocacy organization for children, having crusaded relentlessly since 1973 for improvement in children's lives. The research of the organization is widely disseminated in yearly "State of America's Children"

reports and in reports on special topics and has been frequently referenced in this text.

Advocacy in the context of individual cases is probably most familiar to social workers. Advocacy focused on an injustice and denial of opportunity to an individual child—case advocacy—can be very effective in educating the public about injustice in the system. When cases seem to fall into a pattern and clients face a common barrier to social justice, a class of people can become the subject of advocacy—class action lawsuits to force reform of child welfare systems that are failing to meet the needs of children and families are familiar.[7] Advocacy is inherently political. It is aggressive. It can be confrontational. At its best, it results in community problem solving.

The families that social workers encounter in the child welfare system—poor, often persons of color, sometimes homeless, with serious problems such as substance abuse and mental illness—need our advocacy to improve their lives, and need our support in becoming advocates for themselves. Presenting data, presenting issues, presenting the needs of "their" families to the agency, to the community, and at the state and national levels, social workers are at their best. And as responsibility for programs tends to move from national to state to community levels, their voice becomes louder and their advocacy has more effect.

Critical Issue: Retention of Child Welfare Workers

The recruitment and retention of well-qualified caseworkers presents a huge challenge to child welfare agencies. Public and private agencies work to find and hire men and women who seem to have promise as child welfare workers. Having done so, they invest in further agency-specific training to enhance employees' skills. It is important that they be able to retain those workers. When workers leave, the agency's investment is lost, along with the practice wisdom that a worker has gained during time in the position. Vacant positions mean that the agency infrastructure is strained, as other workers carry larger caseloads and supervisors assume additional duties. They also mean that families and children lose the opportunity to work without interruption with a single worker whom they know and whom they believe understands them and their situation. High turnover rates constitute a critical issue for child welfare practice.

In examining this issue, we begin with a brief portrait of the child welfare caseworker in action. We then turn to an even briefer look at the agency environment of the worker. This background will hopefully be helpful in understanding recruitment and retention difficulties and promising strategies. Focus will be on retention, as there is little point in recruitment efforts if staff cannot be retained.

The Frontline Child Welfare Caseworker

Information about the characteristics of the child welfare worker is limited and is based on various state statistics and national surveys of the past ten years. We know that most child welfare workers are women, white, with a median age in the early forties. Most hold a non-social-work bachelor's degree (National Child Welfare Workforce Institute 2011). Salaries are modest. In a national study, Barth et al. (2008) found that 24 percent of those working in child welfare had BSW degrees and 11 percent MSW degrees. Having a social work degree was associated with higher income and more years of experience. Various studies find that the typical worker's tenure in the current agency is between two and seven years. Most child welfare caseworkers manage ongoing caseloads, often twice the number of cases suggested by national standards (National Child Welfare Workforce Institute 2011). This is, then, an educated workforce with some experience, working in a demanding environment, in a role that involves "high levels of uncertainty, danger, and emotion" (Barth et al. 2008:199).

The demands of that environment challenge the worker. Under the timelines of ASFA,

parents must demonstrate changed behaviors in a relatively short period of time. In order to help them accomplish this, the worker must engage the parents and work with them to change their behaviors toward their children. However, constrained by short timelines, the requirements of documentation and reporting to the court, visiting children, and supervising foster homes, workers may not have enough time to work with families. Workers in Illinois reported spending 50–80 percent of their time on administrative tasks, mostly paperwork (U.S. Government Accounting Office 2003). The limited resources—both services and more concrete resources—available make the task of meeting the needs of families even more difficult.

In a qualitative study of frontline workers, Smith and Donovan (2003) discovered that workers justify, to themselves, their lack of involvement with families by deciding that the families have little to offer and probably won't make any changes—so it is better that they spend their limited time elsewhere. Even maintaining contact with parents seems pointless.

> A caseworker states: "The ones that never call me, a lot of time I won't call them. . . . If they want services, they'll come, they'll contact you.
>
> "Why spend the child's time and taxpayers' money and all of our time and, you know, waste our time on these parents who are never gonna do anything and everybody knows that?" (Smith and Donovan 2003:551)

Service plans are developed by workers from a standard format and are not informed by knowledge of the individual family. Focus then turns to compliance with service plans and completion of various assessments, but not to working toward real change with parents.

This justification of lack of involvement, born of workload and time pressures, and lack of support for best practices is a great disservice to children and parents. One would suspect that, as they are at variance with worker training, they also compromise worker satisfaction. They resemble *burnout*—the term used to describe workers who are overwhelmed, with little left to give. Depersonalization of clients, reduced feelings of accomplishment, and emotional exhaustion are hallmarks of burnout (Sage 2010). Burnout and turnover are closely related.

The Agency Environment

After an extensive review of studies of worker turnover, the Children's Defense Fund (2006) identified the components of a child welfare agency that is capable of retaining staff. Leadership emerged as a critical variable: "child welfare agencies must be led by strong, competent, visionary, and committed child welfare professionals" (Children's Defense Fund 2006:2). The authors note the lack of training for management and leadership positions and the importance of leadership in improving worker performance and effectiveness.

The reviews of research on worker turnover focus on a supportive environment (U.S. Government Accounting Office 2003; Zlotnik et al. 2005; Children's Defense Fund 2006; Barth et al. 2008). This support is operationalized in organizations that are not traditional "top-down" bureaucracies and that allow workers room for independent decision making and are not quick to blame when there is a mistake. It is present in supportive and meaningful supervision, in mentoring, in a culture of peer support, and in opportunities for further education.

Finally, there is agreement that workload must be reasonable, working conditions safe, and compensation competitive with similar work. This means caseloads need to be manageable, and workers must have the support staff and technology to assist them in their work and to keep track of information. Safety is particularly an issue when much work is done out of the office in communities that are sometimes unsafe. Low pay emerges as an issue in many studies, as does the need for training and promotional opportunities (Annie E. Casey Foundation 2003; U.S. Government Accounting

Office 2003; Zlotnik et al. 2005; Children's Defense Fund 2006; Barth et al. 2008).

Turnover Statistics

Turnover rates in the child welfare system are unacceptably high.[8] Based on surveys done by the Alliance for Children and Families and the Child Welfare League of America, average turnover rates in child welfare have been estimated to be between 30 and 40 percent (U.S. Government Accounting Office 2003). In protective services, about 22 percent of workers leave each year (Faller, Grabarek, and Ortega 2010). Anecdotal reports tell of agencies with much higher turnover rates among caseworkers, and in any gathering of agency managers, the disruption caused by turnover and vacancies is a dominant topic.

This high turnover causes significant disruption in the functioning of agencies and in the services provided to their clients. The loss of trained and experienced workers can impact decision making at all points in a child's trajectory through the child welfare system. Additionally, high turnover negatively affects child safety by delaying investigations and limiting the frequency of worker visits to children. Permanency is also delayed, as staff has insufficient time to work with families (U.S. Government Accounting Office 2003). Continuity of workers is important in this planning and work with families and important in the lives of children who have had many discontinuities (Faller et al. 2010).

Additionally, turnover is costly for agencies. When a worker leaves, a new worker has to be recruited and trained. Recruiting and training a new worker costs, on average, one third to one half of a worker's salary (Faller et al. 2010). It takes more than six months to advertise, recruit, and train a new worker sufficiently to handle a full caseload (U.S. Government Accounting Office 2003). In the interim, there are uncovered caseloads and/or workers stretched in trying to cover the work of the absent worker.

In any organization, some turnover is to be expected, as workers leave because of changes in family responsibilities, to relocate, to return for further education, or to retire. Sage (2010), in her study linking organizational culture and climate with turnover, removed this nonpreventable turnover from her sample and found that about one third of the turnover might be due to workplace conditions. It is not clear whether other studies of worker turnover have made this adjustment.

Reasons for Remaining or Leaving

There have been many investigations of the reasons for worker turnover. In a major review of the research on turnover rates, the Institute for the Advancement of Social Work Research (IASWR) identified professional commitment to children and families, level of education, supervisory support, and workload/caseload as the most consistently noted factors associated with retention of workers (Zlotnik et al. 2005). Landsman (2013) in her review found less consistency but noted that supervision and commitment were important dimensions in worker retention. In a review focused on understanding the conditions of the child welfare workforce, the Annie E. Casey Foundation identified the following as reasons workers leave: heavy workload, low status, low pay, poor supervision, and work-family balance. The reasons they stay were sense of mission, good fit with job, investment in relationships, and professional standing (Annie E. Casey Foundation 2003). Also noted were rule-bound jobs that leave little latitude for discretion and drive out the most entrepreneurial workers.

Rule-bound compliance-oriented jobs create a vicious cycle. On one hand, good workers who want some degree of autonomy will not stay in them. On the other hand, poor-quality staff are subjected to overregulation in a last-ditch effort to manage them. Though regulations are intended to build in accountability and ensure a base level of good practice, they fix the process into a one-size-fits-all intervention, ignore results, and are indifferent to high performance. In addition, such regulation constricts flexibility

and inhibits opportunity for professional recognition and career advancement (Annie E. Casey Foundation 2003).

In another large study, using data from the NSCAW study, Barth et al. (2008) focused on worker satisfaction and found supportive supervision to be the most important factor in retention of workers; such supervision may offset lack of opportunity for advancement and lack of recognition. Those with social work degrees had more experience and higher salaries and, among non-urban workers, were more likely to be satisfied with their work (Barth et al. 2008). Managers and supervisors in child welfare identified heavy workload, low pay, and not feeling valued as reasons that workers leave (Drais, Cyphers, and Lengyel 2001).

Commitment Professional commitment to children and families was identified in the IASWR review as a commonly occurring variable positively associated with staff retention. Linked to professional commitment is the finding by the IASWR review that education is positively linked to retention, particularly the Title IV-E child welfare training programs offered in partnerships of child welfare agencies and university schools of social work (Zlotnik et al. 2005). Professional commitment is similar to the sense of mission identified and probably also to the professional standing, identified in the Casey study (Annie E. Casey Foundation 2003). The fit of social work values and skills to work in child welfare was examined earlier in the chapter; though evidence is mixed, research links possession of an MSW or BSW to improved service delivery, job performance, and job satisfaction (Scannapieco, Hegar, and Connell-Carrick 2012).

Organizational commitment also emerges as a critical factor in retaining workers. The commitment to the organization's values and mission was found important by Ellett (1999), who reports that child welfare workers tend to stay as long as they believe they are making a difference, even in the face of low salaries or high caseloads. Workers with high job satisfaction generally do not intend to leave; job satisfaction is positively correlated with organizational commitment. Organizational commitment can disappear abruptly when a shock (such as a violation of the employee's value system) causes the employee to reevaluate his or her attachment to the organization (Morton 2002). This speaks to the need for a clear mission statement that is operationalized in the policies and practices of the agency, so that workers see themselves as carrying out that mission in their everyday work.[9] Morton (2002) points out that although much is written about engaging clients, we seldom discuss engaging staff members and securing their commitment to the organization. Retention of workers, he suggests, may be less dependent on external factors, such as funding, than on changes in management.

Supervisory Support Supervision is a necessary support for any worker in a position as demanding as that of the child welfare caseworker and a critical factor in ensuring quality services. Child welfare practice is complex and requires a high degree of sophistication. There is constant input of new information and ideas; supervisors have a role in helping workers assimilate and use this information. This learning process will be particularly important as workers learn how to access and evaluate the services that will support child well-being. Development of the necessary values, attitudes, and skills requires supervision and coaching over time. Qualities that most closely touch the child welfare worker are the amount of supervision, the competence of the supervisor, and the emotional support received during supervision (Barth et al. 2008). In many studies, these aspects of supervision, particularly supportive supervision, are associated with worker retention (Zlotnick et al. 2005; Barth et al. 2008; Sage 2010; Scannapieco, Hegar, and Connell-Carrick 2012; Landsman 2013).

A Supportive Agency Culture Workers need to feel a sense of competence and pride and

to believe they are valued. The demands of a heavy workload can be alleviated by structures within the agency that provide support in decision making and facilitate access to the needed resources. A work environment that affirms that the caseworker is valued is important. In efforts to improve retention of workers, agencies commonly make efforts to increase worker safety—not only decent and secure office space but also safe cars and cell phones so that workers can stay in touch with the office or summon needed help. Agencies also attempt to simplify reporting requirements (and provide clerical support) so that time can be spent with families rather than on paperwork, make physical plant improvements, and develop flex-time protocols so that work and family will be a better fit (Drais, Cyphers, and Lengyel 2001)—all of these efforts indicate valuing of workers. A supportive agency culture, in which staff members are recognized and good work is rewarded, makes a difference in staff retention and enhances the organization's ability to work with other agencies (Glissen and James 2002).

Part of a supportive agency culture is the support a worker gets from co-workers, mostly in informal interactions. This is thought of as a secondary source of support and is part of the valuing relationships that the Casey study found helped in retention. In a study of culture and climate, Sage (2010) used a scale of peer support but did not find that this dimension contributed significantly to the intention to stay or leave the agency.

Salaries Low salaries are a marker of work that is not valued. Salaries of child welfare workers in 1999 averaged $33,000 in the public sector, $27,000 in the private sector (Annie E. Casey Foundation 2003). That they are rising is indicated by the Bureau of Labor Statistics estimate of the mean annual wage of $45,300 for family caseworkers (working in child welfare and family agencies) in May 2012 (U.S. Bureau of Labor Statistics 2012). Wages vary by job description, by urban or rural, and by part of the country. Salaries were named as a factor in worker turnover by 88 percent of the managers and supervisors in private agencies and by 74 percent of those in public agencies (Drais, Cyphers, and Lengyel 2001). Salaries were also identified as a factor in worker retention in the IASWR research review and the Casey review (Annie E. Casey Foundation 2003; Zlotnik et al. 2005), though Landsman's (2013) review found mixed evidence as to their importance.

Workload Workload pressures and turnover may be linked. Workload emerged in several studies as a reason for intending to leave a position in child welfare (Zlotnik et al. 2005). Managers and supervisors in the public child welfare agencies identify heavy workloads as a major impediment to retention. Specific workload issues are large caseloads and too much time spent on travel and paperwork (Drais, Cyphers, and Lengyel 2001). Again, there are studies with contradictory findings (Landsman 2013). Workload includes demands for court appearances, collaboration with partner agencies, visits to schools, as well as supervision of children in foster homes, and it is possible that it is this multiplicity of tasks that causes stress rather than the absolute number of cases.

Caseworkers develop varied strategies to manage this workload. One strategy is the depersonalization of clients and giving up on efforts to effect change. Other, perhaps more productive strategies involve selecting those families most likely to succeed and working with them, rationing services, or reinterpreting the expectations of the agency (Smith and Donovan 2003).

This high demand creates a situation in which workers do not have enough time or resources to meet the needs of all their clients. And because high demand prevents effective practice, workers do not feel rewarded by the sense that they are "making a difference." Supervisors who can assist workers in prioritizing tasks and organizing time can be a great help. A strong knowledge base helps, as does a well-developed network of community resources.

And supervisors can help workers recognize the importance of the work they are doing and emphasize those facets of work in which it is clear the worker is "making a difference."

Agencies are aware of these caseload pressures and have been endeavoring to reduce them ever since the advent of mandated reporting flooded child protective services with new clients, without funding for more workers. That workload pressure eventually forced the redefinition of child welfare services into protective services, as agencies strove to carve out a part of broader services so that they could meet the demand. Workload also creates resistance now to "best practice" initiatives and is an impediment to the development of preventive services. A major challenge in adding the responsibilities of attending to children's well-being will be using resources efficiently so that additions to workload are minimal and so that the satisfactions of these new tasks are evident.

Education for Child Welfare Services

Given the complexity of the work, the high demand, and the varied support available in child welfare agencies, the best background for child welfare work is often questioned. Some agencies require at least a bachelor's degree in social work or another helping or human service profession; however, many others, due to budgetary constraints or to difficulties in recruitment, hire staff members who lack an educational background in human services. Reliance on "trial by fire"—a loose combination of on-the-job and in-service training for new employees while they carry a full caseload—is particularly problematic when the new workers do not have the appropriate educational background.

The usefulness of professional education in child welfare work is recognized by child welfare administrators. Ritter and Wodarski (1999) describe the skills needed by the direct service worker at the various stages of casework: During investigation, the worker needs "integrated knowledge of psychopathology, advanced assessment techniques, and intervention strategies . . . to work with resistant families" (p. 222); at the intervention stage, "intensive family services require highly trained social workers knowledgeable in family dynamics, family- based interventions, crisis stabilization, advocacy, and brokering services" (p. 228). The authors add that knowledge of child development is necessary in the assessment stage and that skills in direct work with children are needed to help children deal with issues of disrupted attachments (pp. 225–27).[10]

Social work has a long history with child welfare.[11] Many social work programs provide curricula in child welfare as an elective component of the degree program. The components of social work education fit with the demands of child welfare work, and a social work background may enhance a child welfare worker's ability to work effectively and make a difference.

As recently as the 1960s, the need for such skills was widely recognized, and a master's degree in social work was a common requirement for child welfare practice. As the volume of child abuse and neglect investigations swelled and agencies became stressed, a common way of stretching lean budgets was to hire workers with fewer qualifications. As child welfare agencies increasingly worked with involuntary clients, and as the authority of the court was increasingly invoked, social workers deserted the field, finding that the nature of child welfare work no longer fit with their beliefs or with their training (Costin, Karger, and Stoesz 1996:96–98). Social work education reflected this stance, offering little curriculum with direct application to child welfare work. Consequently, child welfare administrators became less interested in hiring MSW graduates, who were apparently no better trained for the work than those without a graduate degree, who could be employed for less.

In the past decades, social work educators have begun to reexamine and even to reverse this stance, offering a broader, family-focused

curriculum applicable to more settings, including the child welfare system. The BSW degree was developed in part to meet a need for workers who would command lower salaries but have relevant education. These workers have made a strong contribution to child welfare service.

Increasingly, public child welfare agencies are drawing on federal Title IV-E funds to pay for training programs. These programs are usually partnerships between a school of social work and a state child welfare agency. They offer a social work degree program. Graduates of these programs are thus trained in the values, ethics, and skills of social work and in the specific application of these to child welfare. These programs are a promising avenue to recruiting students interested in a human service career, as well as a means of providing additional education for current child welfare staff.

Studies of worker turnover suggest that a social work background may aid retention. Barbee et al. (2009) found that graduates of specialized BSW programs were more likely to be retained at a two-year follow-up; at four years, some BSW graduates tended to leave the agency, but about 60 percent became long-term employees. The IASWR study also found that social work education was often associated with retention of staff (Zlotnik et al. 2005). Scannapieco, Hegar, and Connell-Carrick (2012) found workers with a social work degree more likely to remain employed after three years, but also more dissatisfied with work conditions. Landsman (2013), in her review of studies of retention, highlights the need for strong leadership and good supervision and notes the funding of new university-child welfare partnerships to further this goal.

It is important, however, to recognize that child welfare is an interdisciplinary field. Social work skills provide an excellent core. However, expert knowledge from a variety of disciplines provides depth that, when used in team decision making, informs good decisions and supports the workers who make them.

In 1988, only 28 percent of the workers in public child welfare had a social work degree (Lieberman, Hornby, and Russell 1988). By 2008, the percentage had changed very little; 24 percent had BSW degrees and 11 percent MSW degrees (Barth et al., 2008). As partnerships proliferated between agencies and schools of social work, the percentage had been expected to increase; this may be evidence that child welfare agencies are not retaining the personnel they educate.

If social work is a good educational background for child welfare, social workers should feel competent in their work, and that is one factor associated with job satisfaction and retention. The challenge to the child welfare agency is to create the conditions under which social workers are able to use their skills, and thus feel that they are making a difference. The initiatives that have increased the "fit" of child welfare and social work may accomplish this.

Retention Strategies

Responding to the studies that identify reasons that workers leave, agencies are attempting to create more favorable conditions. Investments in supervisory training have been common. Working on the premise that one does not want to train someone who will not stay, another common response has been realistic job previews (videos) that have been developed in many states and are reported to increase retention. Nationally, there is increased focus on the quality of agency-based child welfare training programs. The Children's Bureau, the Child Welfare League of America, the Council on Social Work Education, and the National Association for Staff Training and Development of the American Public Human Services Association have launched collaborative initiatives, convened conferences, and responded in other ways to increase the quality of training offered by agencies and the quality of educational preparation offered through schools of social work.

Ellett (1999) points out that the reasons workers stay may not be the same as the reasons they leave. She points out the importance of feeling

that one is "making a difference"—a feeling of competence, and conditions such that skills can be used. If we recruit workers with aspirations to make a difference in the lives of children and families, that aspiration needs to be nurtured and become, in part, identification with the goals and mission of the agency. Leadership that is strong and can create a supportive organizational environment is important in cultivating this identification. Skilled leadership can create a climate where workers see the agency living up to its own values and philosophy and where workers experience role models (Children's Defense Fund 2006; Landsman 2013).

Community support of the work of a child welfare agency is critical to its success and needs to be developed. The community needs to understand the mission and scope of the agency. Additionally, it needs to have some sense of the methods the agency uses in its work, and thus be supportive of the child welfare worker as family intervention occurs. As child welfare turns more toward comprehensive services to promote the welfare of children, as families are brought more into the process of determining the services they need, and as community agencies become increasingly involved with voluntary services linked to child welfare, this community understanding and support should develop.

For Further Exploration

The committed student of child welfare is at this point asking, "How can this be almost the end of the book? There is so much more that needs to be discussed." Unfortunately, the student is correct: there are important topics that are missing from the book in order to keeps its length reasonable. Most prominent among these is the material on the funding and delivery of child welfare services to the Native American tribes. That is a complex story of a tortured history and promising beginnings of culturally specific services. We have noted that many families are affected by substance abuse, but there is in the book no in-depth discussion of the impact of methamphetamines on children and families or of the resurgence of heroin use—the various drugs, their impact, and prognosis need discussion of too great a length for this text. There is also too little content about children with disabilities and their families, a group that tend to disappear from child welfare materials. More extensive discussion of the interface of child welfare, the health systems (both mental health and physical health), and the education systems would have been valuable. The reader will find other gaps. Hopefully, the references and the notations of websites will start the reader on an independent exploration of these topics.

Conclusion

In this concluding chapter, the reader will have found the major themes of the text drawn together in a new context. Child welfare is changing—it has been changing throughout its existence—but it is undergoing a major change now. For many years, the outcomes of safety and permanency for children have been the goals of child welfare services, and measurement of these outcomes determined the success of the services. Now a new dimension has been added, an explicit concern for the well-being of the children in the system. It is a fundamental change that requires everyone to rethink their work. And the Child and Family Service Reviews are examining the extent of that rethinking, urging the change forward, while data from the National Survey of Child and Adolescent Well-Being also tracks the implementation of the changes.

The change has been triggered by the vast amount of new information generated by multiple research endeavors in the past decade. This new information has illustrated the adversities that children experience, documented the lasting impact of these experiences, and illustrated the conditions that help children toward resiliency.

Foremost among these conditions is continuity of relationships. A different view of parents as people doing the best they can under

often difficult circumstances and as partners in planning for the well-being of their children is emerging. There is a new emphasis on maintaining children in their own homes and minimizing trauma by using relatives when placement is necessary. The push toward permanency that has been in the system since ASFA's passage in 1997 remains. Individualized services to meet the particular needs of a family have assumed increased importance. With the recognition that engagement is critical to use of services, there is new emphasis on including the family in service planning and voluntary use of services. Alternative responses, which incorporate these dimensions, are being tried in protective services.

Interest in prevention has been revived, particularly through the research on early childhood and the impact of both positive and adverse events on brain development and later capacity for attachment and learning. Early childhood education is receiving increased attention. And efforts to strengthen communities to support families better are being tested. There has been considerable inquiry into the effectiveness of specific treatment programs and promotion of using those found effective.

All of these new thrusts have met with mixed success, succeeding on some dimensions, faltering on others. Measuring outcomes of a topic as ephemeral as "well-being" is itself a challenge, and various operational definitions appear in the research. Most are connected to examining the services delivered under the theoretical umbrella of the relationship of the services to well-being. Maintaining family relationships is a dominant thread. This theory will be tested and will probably be more exactly specified in coming years.

These changes are making child welfare a more conformable fit for social work, as the ethics, values, and practice techniques of the profession are increasingly incorporated. One hopes that there is increasing recognition of the high degree of skill demanded of the child welfare worker and of the value of social work education as preparation. Demand from the field and federal funding for education and training may stimulate increased educational opportunities in schools of social work. As agencies hire these workers, their retention is going to become even more critical. The inquiry about the high turnover rates in child welfare services is really just beginning; findings are sometimes contradictory. But commitment to the mission of child welfare, feelings of competence in the work, good supervision, and leadership qualities within the agency are emerging as important.

It is well to note that many aspects of the promotion of well-being for children have been part of child welfare for many years. If not in formal policy, they have existed in the practice of wise and compassionate workers and have been supported by thoughtful supervision and by agency leaders pushing toward a vision of better practice. That is why both children and families often report that they have been helped. That is why the community continues to support child welfare services.

NOTES

1. For example, the Fostering Connections to Success and Increasing Adoptions Act of 2008, which not only increased incentives for adoption but also focused on educational stability for youth in foster care, maintaining sibling ties, and improving health care access; and the Child and Family Services Improvement and Innovation Act of 2011, which requires states to attend to the developmental needs of children and allows the approval of up to ten Title IV-E waiver demonstration projects per year for two years.
2. The case examples in this book are drawn from a research project that was monitoring the ability of Oregon's Child and Family Services division to implement these principles.
3. More than half of the NSCAW sample reported four or more adverse childhood experiences, a level associated with a 12 percent increase in the risk of negative health outcomes as adults, compared with only 13 percent of the adults in ACES.
4. Caseworkers in the NSCAW study report that the greatest service needs are routine health exams and immunizations (69 percent), dental exams

(58 percent), developmental screening and special education (31 percent), and services focused on emotional behavioral health (43 percent).

5. Eighteen months after being referred to the child welfare system, 85 percent of the children in the NCSW sample were living at home, 10 percent with a relative, and 3 percent were in foster care (Dolan et al. 2012).
6. The reader interested in greater depth concerning outcome measures would find an excellent starting place in Poertner et al. (2000) and in Wulczyn et al. (2005).
7. Sheryl Dicker's *Stepping Stones* (New York: Foundation for Child Development, 1990) is a book of five case studies of successful child advocacy and presents interesting examples of successful child advocacy techniques.
8. There are some problems with representativeness of the sample from which these figures were derived, particularly among the private agencies. Those surveyed by the Alliance for Children and Families had only a 30 percent response rate. Of the 551 agencies eligible, the Child Welfare League of America contacted a random sample of 314; only 39 percent returned surveys. It is possible that those agencies that returned surveys tended to be those agencies having serious difficulties with turnover. The estimates are, however, the best available.
9. Staff retention and training is a challenge not only for the public agency; other parts of the system also struggle to recruit and retain trained personnel against similar odds. For example, for attorneys, practice in child welfare as a public defender, a state's attorney, or as an attorney representing Court Appointed Special Advocate (CASA) programs is rarely as remunerative or considered as prestigious as other kinds of legal practice, and the legislature rarely provides sufficient funding for the number of legal professionals needed to meet the demands of these programs. Few lawyers or judges are educated in dependency law or prepared to deal with the intense emotions and life-or-death decisions that can be called for in child welfare casework. To address the education challenge, some law schools (for example, the University of Michigan, Loyola, and the University of Washington) have established child advocacy clinical training programs to prepare law students for this kind of practice. The National Council of Juvenile and Family Court Judges and the American Bar Association Center on Families and the Law have invested heavily in developing training, scholarship, and other professional resources for attorneys and judges practicing in this field.
10. This is an ambitious article. It attempts to analyze the varied tasks of personnel in child welfare and to match those tasks with the skills taught in BSW and MSW programs. Its focus is narrow in that it does not recognize the interdisciplinary nature of child welfare work and the need for contributions from other disciplines.
11. This history is detailed in *Women and Children First: The Contribution of the Children's Bureau to Social Work Education*, edited by Alice Lieberman and Kristine Nelson (Alexandria, VA: Council on Social Work Education, 2013). It is a history of the interactive work of the Children's Bureau and child welfare; contributors are major scholars, and for those that like history it is a fascinating book.

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Appendix

Internet Resources

Throughout the text are addresses of websites that will give you additional information on particular topics. In this section, some additional websites are listed that will be useful as you seek more general information about child welfare.

Federal Sites

Child Welfare Information Gateway. A service of the Children's Bureau, this is a website with a wealth of good information on the prevention, identification, and treatment of child abuse and neglect and on foster care and adoption. It is, literally, an information gateway, a good place to start with a quest for information on any child welfare topic. Print and online materials are available. The website also contains links to state laws and policies. www.childwelfare.gov

U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth, and Families, Children's Bureau. A major source of information and quite easy to use. The website contains links to the federal data reporting systems, as well as fact sheets reporting recent statistics on many aspects of child welfare. Laws and policies are described. Children's Bureau program descriptions and funding announcements are on this website. Many government publications can be downloaded. www.acf.dhhs.gov/programs/cb

U.S. Department of Health and Human Services, Administration for Children and Families, Office of Child Care (OCC). The OCC website focuses on the Child Care and Development Fund (CCDF) including state, territory, and tribal allocations, data about families and children served, program instructions, technical assistance, and special initiatives. www.acf.hhs.gov/programs/occ

U.S. Department of Health and Human Services, Administration for Children and Families, Office of Head Start (OHS). The OHS website contains information about Head Start and Early Head Start including funding opportunities, technical assistance, policy and regulations, data and reports, and upcoming events. www.acf.hhs.gov/programs/ohs

U.S. Department of Education, Office of Early Learning. This website includes information about activities in the Department of Education to improve early learning including federal initiatives, policies, and funding. www.ed.gov/early-learning

Sites Sponsored by States, Private Organizations, or Universities, and National in Scope

American Humane Association. One of the oldest of the organizations to focus on abuse and neglect, this organization works with child welfare organizations to increase the effectiveness of their services. www.americanhumane.org

Annie E. Casey Foundation. An excellent website from an organization dedicated to advocacy and to the development of

public policy to benefit children. Annual "Kids Count" data book and other publications can be downloaded. www.aecf.org

California Evidence Based Clearinghouse for Child Welfare. A searchable website that allows one to identify research on the specific topic of interest. Many topics relating to child welfare practice are presented. A "grading" system allows the user to use the expertise of researchers in finding the "best" evidence. The website identifies areas of practice where there is substantial empirical data. The website is interactive and easy to use. www.cebc4cw.org

Chapin Hall Center for Children. A research and policy institute that has explored many policy issues, with most publications downloadable from its website. It is a major source of data on many child welfare issues. www.chapinhall.org

Child Welfare League of America. A major source of information about child welfare services and a source for information on policy initiatives. Information about the League's annual conference is available on the website, as is an extensive catalog of publications, including standards for practice in many areas. www.cwla.org

Child Trends. Reflecting Child Trends' role as a nonprofit, nonpartisan research center focused on improving outcomes for children, this website includes a data bank with more than one hundred indicators of child and youth well-being, a state child welfare database, a database with information about programs that work to enhance children's development, and a myriad of other resources. www.childtrends.org

Children's Defense Fund. A major advocacy organization, promoting children's welfare, with particular emphasis on issues affecting black children. The website hosts discussion of current issues, policy, laws, and excellent publications. www.childrensdefense.org

Coalition for Asian American Children and Families. Works to improve the well-being of Asian American children through dissemination of information about the needs of these children and families and advocacy. www.cacf.org

Evan B. Donaldson Adoption Institute. An informative website covering many aspects of adoption. Contains reports of surveys, conferences, reviews of laws, material on the costs of various types of adoption, and other hard-to-obtain information. www.adoptioninstitute.org

The MacArthur Network on Transitions to Adulthood. This website contains a great deal of information examining the changing nature of the transition. Extensive data are presented showing trends and profiles. Publications are available. www.transitions2adulthood.com

National Black Child Development Institute. Information on multiple aspects of child development for the black child. Focus on training professionals and empowering parents to maximize child development—all in the context of the African American culture. Links to partner organizations. www.nbcdi.org

National Center for Children in Poverty. An excellent website containing data and policy discussions. Many discussion papers and publications can be downloaded. www.cpmcnet.columbia.edu/dept/nccp

National Center on Substance Abuse and Child Welfare. An organization that provides training and information to child welfare workers, substance abuse treatment personnel, and the courts, with the goal of helping them work together effectively for the benefit of children and families. Materials are well written and informative. www.ncsacw.samhsa.gov

National Indian Child Welfare Association. A website that contains material of

particular interest to those concerned with child welfare issues among the Native American population. It hosts material about conferences, newsletters, discussions of policy issues, and presentation of research and contains information often difficult to find. www.nicwa.org

National Institute for Early Education Research (NIEER). NIEER is focused on conducting and communicating research about comprehensive early education for young children. The NIEER website includes information on the status of early education across states as well as research about the effects of high-quality prekindergarten programs. http://nieer.org

National Resource Center for Child Protective Services. The center helps states, local agencies, and tribes develop effective and efficient child protective services. The center responds to needs related to prevention, identification, intervention, and treatment of child abuse and neglect. www.nrccps.org

National Dissemination Center for Children and Youth with Disabilities. A website for the use of professionals and parents concerned with the care of children with disabilities. It hosts many resources, including a considerable amount of material on evidence-based practice. www.nichcy.org

National Resource Center for Youth Development. The center focuses on increasing the capacity of state and tribal child welfare agencies to meet the needs of youth who will be emancipating from the system. It is easy to use and has state-by state data and a section on tribal resources. www.nrcyd.ou.edu

Pew Research Hispanic Center. A website covering a vast array of topics, including information about families and children, and excellent information about poverty. www.pewhispanic.org

Prevent Child Abuse America. Through a network of affiliated organizations, in all fifty states, the organization works to prevent child abuse through its Healthy Families America home visitation programs, through advocacy for a national policy framework to focus on prevention, and through emphasis on evidence-based interventions. www.preventchildabuse.org

Spaulding for Children. The website reflects the multifaceted organization (a pioneer in the placement of older children for adoption) that provides training, information, and support for foster and adoptive parents and works to place the children who wait longest for adoption. Many documents from the National Resource Center for Special Needs Adoption are archived on this site. www.spaulding.org

ZERO TO THREE. A national organization committed to improving the lives of infants and toddlers through information, training, and supports, ZERO TO THREE's website includes a rich array of resources for professionals, policy makers, and parents. www.zerotothree.org

Sites Used by Parents, Youth, and Professionals

Adopt US Kids. This website is a project of the Children's Bureau. It displays pictures and information about waiting children from across the United States and provides answers to common questions about adoption. Professionals can also use this website to find families for waiting children and to respond to inquiries from studied families. http://adoptuskids.org

Al-Anon and Alateen. Linked to Alcoholics Anonymous, these are organizations to help the families affected by the problem drinking of a family member. The website contains information about the organization and its purpose and about how to connect with a group. www.al-anon.alateen.org

ARCH National Resource Center for Respite and Crisis Care Services. A website devoted to illustration of the multiple uses and value of respite services. It hosts discussion of policy issues, laws, and links to publications. www.archrespite.org

Child Care Aware of America. This website is a respected source of information for parents and child care providers. It provides links to state and local resources including resource and referral agencies that can help parents find child care in their communities. www.usa.childcareaware.org

Foster Club. Foster Club is a national network for children in foster care, with a focus on teen years. "Built for youth, powered by youth, changing life in foster care" its website says. The website contains information about groups, activities, and ways to join the national network. www.fosterclub.org

Foster Youth Informed, Involved, Independent. The website is a partnership between Foster Club.com and the Jim Casey Youth Opportunities Initiative and contains information to help youth make the connections they need to education, employment, health care, housing, and supportive relationships. www.Fyi3.com

National Fatherhood Initiative. The goal of this organization is to inspire fathers to remain with their families and take an active part in raising their children. The website is interesting as it displays the various means the organization uses. www.fatherhood.org

National Foster Parent Association (NFPA). An organization of foster parents that has a lot of information. The website is difficult to access and use. Kidsource, the host site, provides information about children as it relates to fostering. www.kidsource.com/nfpa/index.html

North American Council on Adoptable Children. The website of an organization founded by adopting parents containing information of particular use to such parents, including material on post-adoption services, adoption subsidies, and materials concerning the annual conference. www.nacac.org

Parents Anonymous. The website of a group founded in 1969 to strengthen families and empower struggling parents. It works through self-help groups to support parents in their efforts to avoid maltreatment. The website has information about Parents Anonymous groups, about the help line that the organization sponsors, and about parent leadership training. www.parentsanonymous.org

Rise Magazine. A publication of parents of children in foster care. It works to improve the protective service system and foster care and to support families parenting children with serious difficulties who are involved with the child welfare system. www.risemagazine.org

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