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PROTECTING CHILDREN FROM MALTREATMENT IN THE UNITED STATES

LA PROTECCIÓN INFANTIL FRENTE AL MALTRATO EN LOS ESTADOS UNIDOS

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ABSTRACT: The U.S., known as a western industrialized country with a residual welfare state, has developed a system to respond to extreme family difficulties by focusing narrowly on children's safety and risk of harm from parents or other caregivers. In contrast to many European nations, eligibility for family services is highly restricted and prevention services are typically short-term. For children who are ultimately separated from their parents to secure their safety, the U.S. welfare system places a high priority on returning children home as quickly as possible; and for those children whose reunification is forestalled, alternative opportunities for a permanent home are pursued. This paper suggests that a family system with broader eligibility and more saturated prevention services might benefit many more children and families than those currently assisted in the U.S. today.

KEYWORDS: Maltreatment; foster care; permanency; prevention.

RESUMEN: Los EE.UU. pueden reconocerse como un país industrializado occidental con un estado de bienestar residual. En él, se ha desarrollado un sistema para responder a las dificultades familiares extremas, centrado casi exclusivamente en la garantía de la seguridad y la prevención del riesgo de los niños por daños infligidos por parte de los padres u otros cuidadores. A diferencia de muchas naciones europeas, la elegibilidad para optar a la prestación de servicios para la familia está muy restringida y los servicios de prevención suelen ser de corta duración. En última instancia, se persigue garantizar la seguridad de los niños que son separados de sus padres, en este sentido, el sistema de bienestar norteamericano otorga una alta prioridad a la devolución al hogar lo antes posible, ofreciendo oportunidades alternativas de un hogar permanente para aquellos niños que no vuelven a sus familias de origen. Este artículo sugiere que un sistema familiar con elegibilidad más amplia y con servicios de prevención dedicados a una mayor cantidad de usuarios podría beneficiar a muchos más niños y familias de las que se asisten en la actualidad en los EE.UU.

PALABRAS CLAVE: Maltrato; acogimiento; permanencia; prevención.

1. INTRODUCTION

Raising children in the United States is a largely private affair. The dominant cultural ethos suggests that parents raise children within the context of their extended family and community and that the State plays a limited role in providing advice, general assistance, or support. To contextualize child rearing and the role of the State, we should be reminded that the U.S. does not provide child allowances (as does Spain and many European countries (OECD, 2011)), and financial support to low-income families is very limited. Parental leave is only offered to some parents, and federal law stipulates that leave need not extend beyond 12 weeks and that it need not be paid (Gornick and Meyers, 2003). At birth, parents in some states are offered limited, free in-home visits from public health nurses (Pew Charitable Trusts, 2011), but health care services, in general, typically depend upon private insurance arrangements that vary dramatically by type of employment and income status. Compulsory education is provided free of charge, but not until the child reaches the age of 5; preschool education for 3 and 4 year olds is offered universally in only a few U.S. states (Kirp, 2007), and federally subsidized preschool education is provided to only a fraction of eligible low-income families in others (Head Start, 2013).

The patchwork of services that are available to help parents weather the challenges of family life are highly dependent upon geography – some communities offer a larger array of voluntary services than others – but these services are usually supported at the local level with funding from city or regional taxes and fees; very few universal services are available from the federal government to support family life. As such, the large majority of parents in the U.S. have few formal services readily available to help them raise their children unless they have the financial means to pay for private arrangements.

Instead of a system of universally-based family support services, the U.S. model is residual in nature. The welfare state is typically activated once families have been identified as “in trouble” – when children have been hurt, when children’s behavior falls outside of the law, or when children are likely to hurt themselves or others. It is then assumed that the private assistance of extended family or community has broken down or was insufficient to help the individual family manage the challenges of child rearing.

2. THE “HOUSE” OF CHILD WELFARE

One way to think about the relationship between private families and the welfare-state’s role in child rearing is to consider the image of a house within which state supported services are offered. In some countries, the door allowing entry into the house is large and wide – many families can make their way into the house, they can open the door at any time of day or night, they need not pay a fee to enter, and they can stay as long as they like. In the U.S., the family-service-house has a very small front door. A referral for maltreatment functions like a doorbell and a family gains access to the house when the doorbell signals that the parent has likely maltreated their child.

The family-service-house, or the “child welfare house,” is fundamentally a house of child protection. Some secondary prevention services are offered within, but the majority of services available are tertiary in nature: Protective services are offered after the child is identified as harmed or at substantial risk of harm.

Unlike Belgium or the Netherlands, where children can be identified as “in need” and therefore eligible for state-supported services (Desair and Adriaenssens, 2011; Knijn and van Nijnatten, 2011), or Norway, where a child’s compromised well-being might allow access to services (Skivenes, 2011), the U.S. system is starkly different. Although a parent could ask the state for voluntary child welfare services, this is not the usual route to support and there is no guarantee that the parent’s request might be heeded. Although a parent might need a wide array of services, it would not be typical to receive these unless the child first was identified as a victim of maltreatment. A referral for suspected maltreatment serves as the indicator that the family may be eligible for state-supported services.

Taking our metaphor just a bit further, if the family-service-house is only accessible to some families in some circumstances, then the design of the door and the doorbell are essential tasks of policymakers. In other words, defining the parameters of maltreatment is important because these definitional boundaries clarify which families will gain entry to the house. And determining whether the doorbell must be rung once or many times will also shape who is allowed across the threshold.

2.1. Who rings the doorbell?

The federal government provides wide discretion for states to determine who *may* refer a child for maltreatment, and who *should* make such a referral. As

such, the child welfare system is not one service system in the U.S.; it differs rather significantly by state, and even within states at the local level. In Wyoming and New Jersey, for example, all citizens are mandated to refer suspected child maltreatment to child welfare officials. In all other states, certain professionals who are likely to have contact with children may be required to refer. For instance, clergy are required to refer maltreatment in 27 states; seven states require Domestic Violence staff to refer; 11 states require commercial film processors; almost all states require teachers, medical professionals, and social workers to refer suspected maltreatment (U.S. DHHS, 2012). Standards for referral also vary by state, but usually involve a reasonable suspicion of maltreatment or an observation or knowledge of harm (U.S. DHHS, 2012). In 2011, almost 60% of referrals were made by mandated professionals; approximately one-fifth by friends, neighbors, or relatives (otherwise known as “nonprofessionals”); and another one-fifth were made by anonymous individuals or their source could not be classified.

2.2. When do we open the door?

Only some of the children referred for maltreatment (i.e., the doorbell) are invited into the house (i.e., accepted for services). State agencies are required to respond by assessing risk to the child and screening for service eligibility. Only children who are identified as “victims” must be served by a child welfare agency. Those whose maltreatment referral is not substantiated can be denied services or redirected to community agencies. These community agencies, in turn, may or may not have available services to meet the child’s needs and they are not typically required to provide services to children and families.

In 2011, about 3.4 million reports of suspected maltreatment were received by child welfare agencies nationwide representing about 6.2 million children (45.8 referrals per 1,000 children). Almost two-thirds of referrals (60.8%) were screened-in for a response from the child welfare agency. About one-third of referrals were screened-out for a variety of reasons including the age of the child (over 18), a concern unrelated to child maltreatment, or insufficient information. Among screened-in reports, the typical initial response involves an assessment or investigation of the child’s circumstances (U.S. DHHS, 2012b).

A state’s response to a screened-in report depends, in part, on whether the report falls within the boundaries of that state’s definition of maltreatment. The

federal law giving guidance to the states on these matters is rather broad and allows for state-to-state variation. It reads:

Any recent act or failure to act on the part of a parent or caretaker which results in death, serious physical or emotional harm, sexual abuse or exploitation; or an act or failure to act, which presents an imminent risk of serious harm (Child Abuse Prevention and Treatment Act (CAPTA) (42 U.S.C. §5101), as amended by the CAPTA Reauthorization Act of 2010 (P.L.111–320).

States typically define child maltreatment further, including categories such as child physical abuse, sexual abuse, neglect, and emotional abuse. Some states also include child abandonment, and over half of the states include some aspect of parental substance abuse in the definition of maltreatment (Child Welfare Information Gateway, 2011).

Since the early 1960s, the American consciousness has been sensitized to issues of child abuse. At that time, a seminal work was published, *The Battered Child Syndrome* (Kempe *et al.*, 1962), that served to raise awareness of the phenomenon of child physical abuse. Since then, public understanding about child rearing, developmental well-being, and family welfare have expanded initiating in new conceptualizations of risk and harm. As such, lively debates have emerged in some states as policymakers grapple with the definitional boundaries of maltreatment with the implications of changing the size and shape of the family-service door. In Minnesota, for example, lawmakers have struggled to take into account the implications of adult domestic violence for child welfare. Concerned that children’s visual or auditory exposure to adult domestic violence might constitute harm or risk of harm, policymakers in that state determined that such exposure would constitute maltreatment (Edleson, Gassman-Pines and Hill, 2006). Months later, flooded with referrals for maltreatment too numerous for the state to respond, lawmakers ultimately rescinded the law and the door was narrowed again. Some advocates now argue for an expanded definition of maltreatment to include severe childhood obesity (Murtagh and Ludwig, 2011).

The debates reflect a tension in the U.S. between those concerned about the limited service availability for children with substantial need, and critics apprehensive about state intrusion into private family life. These debates are given fuel, in part, due to the nature of the service array available in the family-

service house. Because services are typically limited to children in the most severe circumstances and – in many cases – are mandated, the child welfare services available to families in the U.S. are often highly stigmatized and may be considered unwelcome by those in need of help.

2.3. Gatekeepers at the door

Screened-in reports of maltreatment require a response from the child welfare agency within a defined timeframe. Depending upon the assumed risk to the child, some states may require an agency response within one to 24 hours; in cases determined to be at lower risk, agencies may respond within one to several days (U.S. DHHS, 2012). Of all children referred for maltreatment in 2011, approximately one-fifth were identified as “victims” by a child welfare agency (U.S. DHHS, 2012b).

To aid decision making in the disposition of a referral, states increasingly rely upon evidence-based assessment tools that guide social workers’ understanding about harm and the risk of future maltreatment to a child. Extensive research on these tools suggests that they can increase the reliability of decision making across cases; improve validity in the classification of risk; and increase equity between families so that social factors other than actual risk do not drive decision making (Johnson, 2004; National Council on Crime and Delinquency, 2013; Shlonsky and Wagner, 2005).

In many states, children’s circumstances are categorized along a risk continuum. Those at highest risk of harm typically are served by a mandatory child welfare system; if risk of harm is identified as low, families may be redirected to a “Differential Response” system where they are offered voluntary family support services.

Differential Response services are developing rapidly in the U.S., based loosely on lessons learned from our European counterparts (Waldfogel, 1998). About ten percent of screened-in reports in 2011 were referred to Differential Response (U.S. DHHS, 2012b). Data are unavailable to indicate the proportion of these families who elected to receive these voluntary services. However, according to one study, over half of families offered community-based Differential Response services did not accept them (Conley and Berrick, 2010). Given the significant historical stigma associated with receiving family-based supports in the U.S., it may take some time before services such as Differential Response gain the traction they might need to gain widespread community acceptance.

2.4. What’s inside the house?

Children accepted into the family-service house because they are identified as “victims” of maltreatment may enter a room that provides voluntary or involuntary services. The proportion of children receiving voluntary services is about twice as large as the proportion receiving mandatory services; of all children identified as “victims” in 2011, almost two-thirds received time-limited in-home, voluntary services (U.S. DHHS, 2011). According to sources at the Government Accountability Office (2013), however, funding for these services is inadequate, so the duration of the service experience is typically very limited.

Mandated services may be offered to families where risk to the child is considered high and where the family may be reluctant to participate voluntarily. Some families may be required by the courts to participate in services at home. In other cases, children may be separated from their parents and placed in substitute care temporarily. In 2011, approximately 250,000 children were placed in out-of-home care (US DHHS, 2012c).

2.5. The living quarters of out-of-home care

When the State separates children from their parents it does so following guidelines about the nature of the setting where children will live, with whom, and for how long. Separations are intended to be temporary while parents change the circumstances that risked their child’s safety. When parents’ problems have been resolved, children are expected to return to the birth home so that the state can retreat from the private matters of family life.

Federal law indicates that children should be placed in the “least restrictive (most family like) setting available and in close proximity to the parents’ home” (Adoption Assistance and Child Welfare Act (AACWA). Pub. L. no. 96-272, § 475(5) (A), 94 Stat. 500, 510, 1980). Recent law also specifies that placement preference should be given to children’s relatives whenever possible (Fostering Connections to Success and Increasing Adoptions Act H.R. 6893 (P.L. 110-351) 2008).

As such, states are increasingly reliant upon children’s relatives – otherwise referred to as “kinship care” – to serve as substitute caregivers. Nationwide, about 27% of children in care were living with their relatives in 2011 (Child Welfare Information Gateway, 2013). In some states, utilization of kin is much greater. In California, for example, about 36% of children resided in kinship foster care in 2013 (Needell *et*

al., 2013). Not surprisingly, the average kinship foster parent has demographic characteristics that largely mirror the child welfare population, indicating considerable social disadvantage. Almost two-fifths live below the U.S. poverty line, and over one-quarter have not completed secondary education; the majority are single, and many struggle with significant health conditions (Annie E. Casey, 2012; Falconnier *et al.*, 2010; US DHHS, 2007).

Almost half of all the children (47%) in out-of-home placements live in foster family care (Child Welfare Information Gateway, 2013). Foster parents are typically strangers to these children, they care for one to six children at a time (though the best estimate suggests that the average is three (NSCAW, 2007), and they are paid a small stipend to cover some of the basic costs associated with board and care. Information regarding the characteristics of U.S. foster parents is woefully inadequate, but based upon a range of studies the portrait of caregivers that emerges suggests that U.S. foster parents are usually over the age of 40; about half are married; they are high school educated; a minority have a college education; and about 40% work full-time outside the home. The typical foster parent is more likely to be poor or living on a low-income compared to the average U.S. parent, and about 20% have annual incomes below the U.S. poverty line (Hare, 2007; Zinn, 2009). In short, although their social disadvantage is not as great as kinship foster parents, foster family caregivers typically do not offer children significant social opportunities.

Congregate care is available to some children. About 15% of children live in group homes or institutions, a decline from 18% less than a decade ago (Child Welfare Information Gateway, 2013; Field, 2011). States may use congregate care facilities while they seek out a longer lasting, more family-like setting, or children may be placed in congregate care if less restrictive settings have failed to properly attend to children's needs. Children in congregate care are usually older and are more likely suffering from mental or behavioral health problems that need intensive supervision and support (Alpert and Meezan, 2012; McMillan *et al.*, 2005; Wulczyn *et al.*, 2005).

Because care is designed as temporary, and due to recent legislation and accountability measures imposed on states, the length of time children remain in out-of-home care may be declining. Although the median length of stay for children exiting care has increased somewhat during the past decade from about 11 to 13 months, the proportion of children remain-

ing in care longer than three years has declined during that same period of time (Child Welfare Information Gateway, 2013).

2.6. Where's the back door to the house?

When children are separated from their parents, the system is designed to immediately prepare for their exit. Soon after a child is placed in care, a case plan is developed to identify children's safety threats and the circumstances that must change in order to reduce the dangers to the child. It is important to note that the case plan may include steps for improving the well-being of a child, but this would not be a condition for returning the child home. Instead, as a system that revolves around children's protection from harm, U.S. child welfare focuses narrowly on improving safety and reducing risk of harm. Thus, the first goal of the child protection system once children are removed from their parents' care is a return home, referred to as reunification.

The State is obliged to refer parents to services that might assist in reducing children's risk – these might include, for instance, services related to drug or alcohol treatment, mental health, parenting, or domestic violence. The State is only responsible to offer services for 18 months. When parents can prove to the court that they have complied with their case plan within the 18-month time frame and have reduced the conditions of risk that brought the child into care, children are typically returned to the birth home. About half of children removed to foster care are returned to their parents via reunification. Rates of reunification have remained relatively stable over the past decade hovering around 50%. Analyses of entry cohorts in some states suggest modestly rising rates of reunification. In California, for example, rates of reunification after 18 months in care rose from about 47% of all first entries in 2000 to about 56% in 2010 (Needell *et al.*, 2013).

In some cases, parents may be unable or unwilling to change the circumstances of their caregiving. If the State can show that it made reasonable efforts to secure children's return home and that the parent did not comply with the case plan within the time frame offered, the State must make alternative permanency arrangements for the child. Typically, the preferred permanency outcome for children who are unable to return home is adoption. Under adoption, the parent-child legal relationship is terminated by the State and the child's full care and custody are transferred to an alternative adult. Adoption is a lifetime relationship that gives children all of the opportunities and privi-

leges available to a birth child. About half of all children adopted out of foster care are adopted by their foster parent; one-third were adopted by an extended family member (US DHHS, 2012c). Rates of adoption have remained relatively stable in the U.S. over the past five years with over 50,000 children adopted per year (US DHHS, 2012c).

Other permanency arrangements that may be secured for children include legal guardianship wherein parental rights are retained by the birth parent, but custody is transferred to the guardian. The legal relationship is usually retained until the child turns 18, at which point the juvenile court withdraws when the child becomes an adult. Kinship foster parents frequently prefer legal guardianship over adoption because parental rights need not be terminated (Testa and Cohen, 2010). Although infrequently used as a permanency tool (fewer than 10% of children leave foster care for legal guardianship each year (Child Welfare Information Gateway, 2013)), exits to guardianship have doubled over the past decade.

Finally, other permanency options may be pursued including informal arrangements with relatives (about 8% of exits), or legal emancipation at age 18 (about 11% of exits) (Child Welfare Information Gateway, 2013), but very few children remain in care throughout their childhood. According to one study including an entry cohort of infants placed in care in California in 1999-2000, an examination of children's circumstances nine years later showed that only 5% remained in long term foster care (Magruder, 2010).

3. RE-CONSTRUCTING THE HOUSE OF CHILD WELFARE

The child welfare system as it is currently designed is highly unresponsive to the large number of parents who would like and who need both basic and substantial assistance raising their children. Parenting is difficult even in optimal conditions; parenting for low-income families, for young parents, for parents of children with disabling conditions or special needs, can be especially challenging. Because the doorbell to the child welfare house is only activated when children have been harmed or are at risk of harm, families who are struggling within the boundaries of appropriate parenting often continue to struggle or – if they have the means – they seek assistance through private pay arrangements.

For the families that eventually come to the attention of child welfare authorities because of an allegation of maltreatment, State intervention is either high-

ly intrusive (i.e., out-of-home care) or it is time-limited and insubstantial. If the door were different and families could access services based upon need rather than risk, services might be less stigmatized, parents might welcome State involvement and – importantly – families from a less intensive risk pool (i.e., with fewer problems) would seek services. The evidence on the effectiveness of many family support services suggests modest improvements in child well-being, family functioning, and the risk factors associated with maltreatment (Al *et al.*, 2012; Mikton and Butchart, 2009; Reynolds, Mathieson and Topitzes, 2009). Common elements across programs with more substantial effects include service intensity, dosage, breadth, and implementation by professional staff (Reynolds, Mathieson and Topitzes, 2009). In other words, family support services would likely have important effects for families struggling with parenting and the associated challenges of child-rearing, even if these services had few effects on reducing maltreatment itself.

But the doorway is narrow and fixed and the political will to adjust the point of entry has remained stubbornly intransigent to substantial change. As such, many critics of child welfare have pointed to the rooms inside the child welfare house as their targets for reform. The criticisms are born out of layers of well-founded concerns about the nature and quality of out-of-home care, and the ultimate consequences to children and families. Out-of-home care is considered a highly intrusive state intervention into the private lives of families. The quality of care provided in foster care has always been variable; as we learn more about the demographic, social, and inter-personal characteristics of typical foster parents it is uncertain how capable many caregivers may be in providing the intensive rehabilitative care children may require (Berrick, 2008a). Questions of targeting have always dogged the U.S. child welfare system with African American and Native American children highly over-represented in care settings compared to their representation in the general population (Anyon, 2011; Drake, Lee and Jonson-Reid, 2009). And kinship care, initially offered as an appropriate family-based alternative to foster care, has instead raised as many questions as it has answered. Whether kin should be regulated by the State to provide care they might otherwise provide voluntarily and informally may suggest an over-reach of the State that goes beyond what may be needed (Berrick, 2008b; Roberts, 2002). If the outcomes following out-of-home care were uniformly positive, public enthusiasm for care might be greater, but the young adult lives of those who spent time in foster care are often characterized by extreme disad-

vantage with high rates of homelessness, incarceration, early parenting, and social assistance reliance among foster care alums (Dworsky, 2008). The typical foster care intervention either comes too late, or is insufficiently robust to counter the deep trauma sustained at the hands of birth parents.

Recent efforts by many in the child welfare advocacy community have begun to question the framework of foster care itself. An initiative funded by the influential Casey Foundation to “safely reduce the number of children in foster care by 50% by 2020,” (Casey Family Programs, 2010) speaks to the sense of urgency that is felt on this issue. Rather than redesign the front door or the foster care room, recent efforts simply focus on downsizing or shrinking foster care, either exiting children who should no longer be in care, closing the door at entry, or simply re-directing children to alternative settings. The data bear this out: At the start of this century the foster care caseload peaked at approximately 567,000 children in care (US DHHS, 2012d). A decade later, caseloads had declined by almost one-third and most recent estimates put the number of children in care nationwide at about 400,000 (US DHHS, 2012c). Many states now re-direct children to the care of relatives under informal, voluntary arrangements rather than place children formally in foster care (Annie E. Casey, 2013). At this time there is no clear evidence showing whether the outcomes for children in these unsupervised, unreimbursed, unregulated settings are different from the outcomes for children placed in kin or non-kin settings under the supervision of the courts and child welfare agencies.

Other factors may explain the fall of the foster care caseload. Research by David Finkelhor and Jones (2006) suggests that the U.S. may be undergoing a period of real decline in child maltreatment, though these reductions do not correspond directly with the steep drop in foster care. Philosophical shifts in child welfare practice that promote reliance on extended family members (Landsman and Boel-Studt, 2011) may also be at play. Whatever the reason, foster care does not dominate the landscape as it did only a decade ago.

Other efforts to reconfigure the child welfare house involve enlarging the room that offers voluntary, in-home services. As an example, as some counties gain greater resources or greater flexibility with the resources available, many invest in voluntary services for families who do not pose imminent risk of harm to children. In one large urban county, the use of in-home voluntary services grew 200% from 2001-2013 at the same time that the rate of first entries to foster care fell from approximately 1,195 children per year to

431 children per year – a 62% decline (Clancy, 2012). It’s important to note, however, that access to these supportive services is still only available to those families who have been identified as maltreating their children; the much larger population of parents who may need assistance with parenting, or the children whose well-being needs are currently compromised, have no entitlement to government-directed support.

4. CONCLUSION

The U.S. child welfare system is in the midst of change, reducing its reliance on foster care and increasing its use of voluntary, in-home services. In this regard, it continues a longstanding trend to model new practices after its European counterparts who for some time have relied heavily on the use of voluntary services with families (see Gilbert, 1997; Gilbert, Parton and Skivenes, 2011). These developments, to expand the use of voluntary in-home services and reduce mandatory out-of-home care, are akin to re-arranging the rooms within the child welfare house. The effect is profound, particularly for service recipients who typically represent some of the most vulnerable children and adults in the U.S. and who might prefer a lighter touch from agents of the state. For child welfare workers, emerging evidence seems to suggest that they prefer these new paradigms of practice which allow for greater use of family-based, collaborative, voluntary approaches (Ferguson and Duchowny, 2012). But rearranging the rooms in the house does nothing to change the fundamental architecture of the house of child welfare. That is, without changing the size or scope of the front door, the house of child welfare still only serves the children and families who are allowed entry based on an allegation of maltreatment. In that regard, the U.S. child welfare system represents a model quite distinctive from many of its European counterparts; one that is selective instead of universal; reactive instead of proactive; residual instead of institutional; and characterized by low levels of defamilisation (Esping-Anderson, 1999).

Some observers of the current child welfare system argue that many needy children and families are left out of the house altogether (Berrick, 2008a; Wald, in press) even though it is widely acknowledged that millions of U.S. families could benefit from a different system that offered support, guidance, and advice well before children’s well-being was compromised by harm. The house of children’s well-being has yet to be constructed, however, and blueprints for its design may take some time to draft.

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