Punitive Protection:
Child Welfare and Perinatal Regulation in the United States, 1935-2000

By

Matty Lichtenstein

A dissertation submitted in partial satisfaction of the

requirements for the degree of

Doctor of Philosophy

in

Sociology

in the

Graduate Division

of the

University of California, Berkeley

Committee in charge:

Professor Cybelle Fox, Chair
Professor Calvin Morrill
Professor Ann Swidler
Professor Raka Ray
Professor Jill Duerr Berrick

Summer 2021

Punitive Protection:
Child Welfare and Perinatal Regulation in the United States, 1935-2000

Abstract

Punitive Protection:
Child Welfare and Perinatal Regulation in the United States, 1935-2000

by

Matty Lichtenstein

Doctor of Philosophy in Sociology

University of California, Berkeley

Professor Cybelle Fox, Chair

This dissertation argues that the expansion of American child welfare's infrastructural capacity and legitimacy to intervene in families (1950-1980) enabled state and federal legislators to authorize new child welfare interventions in substance-using pregnant women (1980-2000). To explain this complex and multi-decade process, the dissertation draws on four types of data: archival research, including three sets of reconstructed survey series on child welfare; content analysis of more than 2,000 professional journal articles from 1950-2000, legislative historical research, and purposive interviews. This data supports findings described in chapters 3-6.

Chapter 3 explains the institutional development of American child welfare in the aftermath of the Social Security Act of 1935. Integrating archival and reconstructed historical survey data, this chapter demonstrates how child welfare shifted from a population-focused paradigm—in which public child welfare proponents constructed children as a population group in need of comprehensive medical, social, and childcare services, justifying a massive infrastructural expansion—to a problem-focused paradigm, in which expanded resources were increasingly funneled to a narrowed jurisdiction over a single issue: parental maltreatment of children.

Chapter 4 shows how the transformation of child welfare into a system devoted to the surveillance of parental behavior encouraged the development of risk assessment instruments. These tools in effect translated structural inequalities like poverty, racial discrimination, and health issues, into risk factors for maltreatment. Combined with mandated reporting requirements and funding incentives that favored child removal over family preservation and poverty relief, a focus on risk functioned as a funnel effect, drawing multiple issues into the jurisdictionally contracted purview of child welfare over child maltreatment.

Chapter 5 analyzes professional discourses in medical and social work journals, demonstrating how child welfare's focus on risk prevention enabled a professional framing of a substance-exposed infant (SEI) as the paradigmatic case of a child at risk. As prenatal substance use attracted media and professional attention, child welfare agencies received an increasing number of reports. Unlike the front-line medical professionals who first encountered pregnant substance-using women, child welfare's power of child removal and focus on long-term risk

prevention positioned them as the de facto regulators of substance-exposed infants and their mothers.

Chapter 6 explains the culmination of this institutionalization process. Throughout the 1980s and 1990s, legislative efforts to criminalize substance-using pregnant and postpartum women consistently failed, and state legislators—and by the 2000s, the federal government—increasingly passed laws mandating the reporting of substance-disordered pregnant women, mothers, and newborns to child welfare authorities. Research on national trends, combined with case studies of California and Wisconsin, show how legislators from both sides of the political aisle harnessed child welfare's legitimacy as a protective authority to expand perinatal interventions. Through a multi-level explanation of this understudied and frequently misunderstood process, this dissertation reveals how the institutionalization of child welfare shaped the development of perinatal protective policies in the United States.

CONTENTS

FIGURES

TABLES

ACKNOWLEDGEMENTS

Writing this dissertation took more time, energy, and tangential research paths than I could have ever imagined. Its completion is thanks to the support of academic mentors, friends, and family, whose efforts on my behalf exceeded my every expectation. Cybelle Fox, my dissertation chair, has guided me as I navigated giant piles of data, seemingly eternal revisions, and the constant anxiety that this project would never end. Cybelle's reputation for brilliant scholarship and her incomparable knowledge of American welfare policy was, I must admit, not the primary reason I chose her for my chair. Instead, from my very first interaction in her office, Cybelle's kindness and generosity of spirit were obvious. Having a warm and supportive chair, it turns out, is just as important as having one that challenges you to produce the best possible scholarship you can. Cybelle did both, and I am forever grateful for that.

My committee members spoiled me with constant feedback that improved every draft of my dissertation and my research papers. Calvin Morrill not only helped me develop my dissertation research, he encouraged my publications on methods and on educational policy, reading innumerable drafts and providing thought-provoking ideas in every conversation and e-mail. During the long years as a visiting student on the other side of the country, my regular conversations with Cal sustained me, encouraging me to keep pushing my research forward. I am deeply grateful for his generosity with his time and his knowledge. Ann Swidler advised me on my MA and qualifying exams, shepherding my early work and providing brilliant and detailed comments on every paper and chapter I sent her. Every conversation with her has been a delight, starting with my first visit to the UC Berkeley campus. Raka Ray taught me so much about concepts of gender and sexuality, which underpin my research. Her thoughtful feedback and her patience with my convoluted path to a PhD have been invaluable.

Jill Duerr Berrick, with her comprehensive knowledge of all things child welfare, has saved my research from embarrassing errors more times than I would like to remember. Her flexibility, kindness, and thoughtful insights have reshaped my understanding of child welfare. I am so very glad that I chose to audit a class with Jill early in graduate school, and I am grateful that she agreed to join my committee.

I have also benefited from academics at UC Berkeley and beyond, in ways both intellectual and emotional. Cristina Mora redeemed academia for me by sharing her brilliant co-working method, which has been the secret sauce to this dissertation and has helped so many graduate students and scholars. In group discussions with Cristina during co-working sessions, I learned so much from her about scholarly productivity, motherhood in academia, time management, and quite simply, how to be a happy academic. I am also grateful to the Institute for the Study of Societal Issues at UC Berkeley for housing these co-working sessions and providing me with office space in a building with a truly diverse, stimulating, and generous community of scholars. The friends I made in these co-working sessions have become some of my closest colleagues.

In particular, I want to thank Marie Mourad, whose friendship made the dissertating process a much livelier and friendlier experience than it's supposed to be. Navigating academia, policy, PowerPoint revisions, and family together has made for a lasting friendship. It is rare to find someone you like as much as their spouse. Thank you, Alex Barnard, for your endless edits on my papers over the years, and for our many conversations from year one until this day. I look forward to many more. Alex Roehrkasse, Casey Homan, and Lindsay Bayham impressed (and slightly terrified) me with their brilliance when I first encountered them in our first year in

graduate school, but it was their friendships that sustained me through the years. During my time at UC Berkeley I formed a friendship and intellectual collaboration with Zawadi Rucks-Ahidiana. Thank you, Zawadi, for saying all the things that nobody else says, for showing me—and so many others—that there are many ways to be an academic and a human all at once. Thank you for personifying mentorship and the possibility of a well-lived life in academia.

I spent multiple years of this dissertation process as a visiting student in other universities. I am grateful to the support of faculty and administrative staff in the sociology departments at Princeton University, New York University, and the University of Pennsylvania. I am particularly grateful to Melissa Wilde, who was kind enough to take an interest in my research when I still wasn't quite sure what it was, and who has remained a valued mentor. It was during my time at NYU that I discovered the friendship and wonderful mind of Jessica López-Espino. I look forward to continuing our tradition of delicious meals and great conversations.

This dissertation was only possible with the research assistance of others who took the time to help me with my work. Legal librarians, from UC Berkeley to University of Pennsylvania to New York University, were invaluable, and I especially want to thank Dean Rowan, of UC Berkeley Law School, for responding in enormously helpful detail to my every question. Undergraduate assistants were crucial to my data collection process, and in working with them, I often learned as much as I taught about the research process, collaboration, and what scholarship is made of. I note all of my research assistants by name in the methodological appendix, but I especially want to thank three brilliant UC Berkeley students who each contributed more than two years of research assistance: Sofia Guo, Tuong-Vi Nguyen, and Raymond Wang. Thank you so much for your incredible work. I am also grateful to the Paul and Daisy Soros Fellowships for New Americans program for both its generous financial support, and for introducing me to a network of brilliant and wonderful people that continue to make a lasting impact on me.

The people who rarely or never read my work were the ones who made it all possible. My sister Judy and her wonderful children Ari, Tziporah, and Avi, helped bring laughter and joy into my life even when we were thousands of miles apart. Moving to Berkeley transformed my life, well beyond the intellectual experience, because I discovered the true meaning of community at a place I will always consider my spiritual and social home: the wonderful Congregation Beth Israel. It was in this community that I met the brilliant, kind Zvi Rosen, a man of profound love, compassion, and strength, a man who inspired the best decision of my life—to join together and make a forever home. Zvi, you are the axis to my spinning universe. Thank you for everything, but especially, for making home a place of joy and endless love for us and our family.

Finally, I dedicate this dissertation to our daughter, whose happiness and love was something I could not imagine before she joined our world, and to the child whose arrival we joyfully await as I complete this dissertation. As I write about mothers facing profound challenges in parenting and childbearing, my toddler's hugs and a small kicking being inside me remind me of why this work is worthwhile.

CHAPTER 1. INTRODUCTION

Research Puzzle and Argument

In recent decades, federal and state regulation of substance-using pregnant and postpartum women has rapidly grown. Congressional revisions to the Child Abuse Prevention and Treatment Act (CAPTA) have strengthened provisions for substance-exposed infants (SEI) in 2003, 2010, and 2016, mandating reporting to child welfare services and requiring a plan for safe care of the infants. Maternal and perinatal[1] protective regulations on the federal and state levels have mushroomed since the 1970s, with a particular focus on substance use during pregnancy.[2] (NCSL 2017; Child Welfare 2015; Fed. Reg. 2002; UVVA 2004). These policies stem from health and safety concerns for children affected by maternal substance use, although outcomes vary greatly depending on maternal usage.

Evidence-based multi-disciplinary approaches have been shown to be the most effective approach to this complex problem (SAMHSA 2016), but current federal and state laws consistently place primary responsibility for addressing this issue on child welfare services (Child Welfare 2019).[3] American child welfare consists of a network of local, public, and private agencies focused on child safety, charged with intervening in families reported for child maltreatment—including abuse or neglect—and either providing support services or separating children from families deemed unsafe. Child welfare interventions are reviewed and either approved or disallowed in courts that are civil, as opposed to criminal courts. Civil courts and law generally require lower standards of evidence, compared to criminal courts, for decision making, including child removal, and child welfare courts in particular have relatively little transparency in their processes. Because child welfare is a highly fragmented system, with its interventions sanctioned by an opaque and inconsistent court system and its resources and mandated interventions varying based on local and state funding and laws, child welfare agencies' capacity to help families varies by region. This inconsistency, coupled with professional training in social, not health, services, and a perception of child welfare as a punitive and racialized system that disproportionately targets poor families of color by some, makes it a problematic choice for primary authority over a complex medical and social problem of prenatal substance use. While an interdisciplinary response involving social services (including but not limited to child welfare), financial aid, and health services would seem most appropriate, the past few decades have seen a general shift away from such an approach.

Based on this policy context, I initially began my dissertation research with a focus on explaining how a complex maternal and neonatal health issue—drug and alcohol dependency during pregnancy—fell primarily under the jurisdiction of child protection agencies, a question that was not answered by the existing literature. The link between perinatal protective policies and child welfare is largely ignored by current sociolegal scholarship on the regulation of

[1] "Perinatal" indicates the period before, during, and in the immediate aftermath of childbirth.

[2] See Federal Register, Vol. 67, No. 191. Wedns., Oct. 2, 2002. Rules and Regulations, Department of Health and Human Services; Unborn Victims of Violence Act, P.L. 108-212 (UVVA), 2004; National Conference of State Legislatures (NCSL). 2017. "Fetal Homicide State Laws." Available at: http://www.ncsl.org/research/health/fetal-homicide-state-laws.aspx, accessed June 21, 2021. See also: Child Welfare 2019; Roberts et al. 2017; Thomas et al. 2018.

[3] See also revisions to the Child Abuse Treatment and Prevention Act (originally P.L. 93-247, 1974), as amended in the Keeping Children and Families Safe Act of 2003 (P.L. 108-36), the CAPTA Reauthorization Act of 2010 (P.L. 111-320), and the Comprehensive Addiction and Recovery Act of 2016 (P.L. 114-198).

motherhood, which explain these policies as: 1) a strategy of anti-abortion and fetal rights advocates, a deeply partisan and ideologically driven "backlash" against reproductive rights (Daniels 1996; Dubow 2010; Paltrow and Flavin 2013; Raz 2020; Roth 2003); 2) a part of the anti-drug movement and a form of controlling women of color in particular, by targeting poor drug users (Gomez 1997; Roberts 1997); 3) the consequence of scientific advances—specifically ultra-sound images of the fetus—that allowed the public imagination to separate the fetus from the mother, combined with medical authorities' successful efforts to expand their authority over all obstetric issues (Dubow 2010; Franklin 1991; Luker 1998). Much of this literature focuses in particular on the criminalization of substance-affected mothers, sometimes conflating criminalization and child welfare interventions, and often linking these interventions to punitive abortion laws (Amnesty 2017; Roberts 1997; Solinger 1998).

My research findings confounded this narrative. Historical research on legislative efforts to pass laws criminalizing substance-abuse during pregnancy reveal that such proposals have failed in nearly all states, across the political spectrum.[4] Instead, I found that approximately 26 states have laws mandating reporting of substance-exposed infants to child welfare services, with a total of 42 states reporting formal or informal policies that mandate reporting to child welfare (Child Welfare 2019; GAO 2018).[5] In my research on how child welfare institutions first became involved in perinatal regulation in the 1980s and 1990s, I found that interventions in substance-exposed infants are part of a larger story of child welfare's institutional development in the context of shifting American welfare governance norms. As I explored this thesis, my question evolved into two distinct but closely linked primary research inquiries: How did child welfare agencies become institutionalized as the primary regulatory authority over American families? How did this institutionalization aid in the expansion of their authority over substance-exposed infants? In digging through archives, historical journals, and legislative materials, I developed the following two-part claim. First, my findings describe the transformation of American child welfare from a sparsely staffed agency network focused on multiple children's issues into a multi-billion-dollar system narrowly focused on child maltreatment. Based on this research, I then demonstrate how the growth and legitimation of child welfare infrastructure and jurisdiction (1950-1980) enabled legislators to expand regulation of substance-using pregnant women by empowering child welfare interventions (1980-2000).

I explain this complex institutional development process with a theory that contributes to sociological research on how regulatory authority is constructed, expanded, and legitimized over formerly unregulated arenas of social life: In order to explain how child welfare became a widespread family regulation system from womb to adulthood, especially and disproportionately for poor and minority families, we must understand its institutional development—specifically, how shifts in its *infrastructural capacity* converged with changes in its *jurisdiction* to shape its regulatory authority, funneling an increasing number of factors, eventually including prenatal drug use, into child welfare's authority over American families.

Empirically, the dissertation research findings demonstrate how, from 1950-1980, child welfare moved from a focus on providing all necessary resources for a specific *population*—

[4] As discussed in Chapter 6 in more detail, there are three arguable exceptions to this: Alabama and South Carolina criminalize women based on other laws and case precedent, not an explicit statute that criminalizes perinatal drug use. Tennessee had a short-lived fetal assault law in 2014-2016, but efforts to revive it have failed (Lewis 2016).
[5] The number of states with laws on the books mandating reporting of substance-exposed infants fluctuates by year, so this number is an estimate. In practice, because CAPTA now requires such reporting for state funding eligibility, most states have such policies, even without formal statutes (GAO 2018).

children—to a focus on a specific *problem*—parental mistreatment of children. A population-to-problem shift enabled a greater focus on risk, allowing child welfare actors' interventions to expand from issues directly affecting the child to risk factors in the environment of the child, including problems like substance use and prenatal maternal behaviors. A focus on risk expanded the boundaries of legitimate child welfare surveillance—anything that could be deemed a risk factor fell under its jurisdiction. Their expanded infrastructural capacity and narrowed risk-focused protective jurisdiction in turn enabled state legislatures to legitimize child welfare agencies as the primary authority over substance-exposed infants by the 1990s. Ultimately, my dissertation shows how the gradual institutionalization of child protectionism, in the form of an infrastructurally expanded and jurisdictionally empowered network of child welfare agencies, helped shape bipartisan family and perinatal policies that affect the lives of women and children throughout the United States.

This introduction first lays out the two major empirical contributions of this dissertation, engaging with literatures related to child welfare and reproductive regulation. I then present the theory generated based on my data analysis, and I explain the contribution of this theory to literatures on state and policy development. Finally, I provide a brief methodological overview (further expanded in a longer methodological appendix) and a chapter-by-chapter overview of the dissertation.

Dissertation Findings

In the overview of my dissertation findings provided below, I divide the main empirical claims into two chronologically ordered sections: first, my contributions to our understanding of the institutionalization and development of American child protective authority, and second, how that process eventually shaped the legislative regulation of maternal behavioral norms.

Empirical Contribution I: American Child Protection Development

My dissertation overturns the conventional narrative of the rise of contemporary American child protection. Current histories of child welfare, highly cited across the literature, build on the following historical claims: modern American child welfare is rooted in the 1960s "rediscovery of child abuse" as a social problem, one linked to individual parental pathology. While child abuse was an important focus among volunteer child protection societies as early as the 1870s, by the 1930s, the issue largely disappeared from social work and child welfare interests. Medical researchers "rediscovered" the issue in the 1950s, and together with bureaucrats and non-profit activists, they challenged widespread professional and public ignorance and advocated for state interventions in parental abuse and neglect of children in the 1960s. Their efforts led to significant media coverage, fueling the passage of state-mandated reporting laws across all fifty states by 1967, which in turn spurred a massive growth in child maltreatment reports by the 1970s (Costin, Karger, and Stoesz 1996; Myers 2006; Nelson 1984). The resultant skyrocketing growth in child removals and foster care placements galvanized a massive increase in federal and state-funded child welfare resources, greatly expanding a system focused primarily on child maltreatment (Green, Boots, and Tumlin 1999; Lindsey 2004; Rymph 2012). In this framing, agenda-driven professional advocacy played a key role in the development of a maltreatment-focused child welfare system that predominated by the 1980s.

As Chapter 3 of this dissertation outlines, I find historical evidence that foundational aspects of this claim are factually inaccurate. Child welfare agencies and employees did not "rediscover" child abuse. In fact, child maltreatment—which includes both abuse and neglect—

was one of multiple child welfare issues, including poverty, health issues, and education, that occupied a small and fragmented child welfare system in the 1930s-1950s. Instead, I argue that from 1935-1980, child welfare shifted from a population-focused paradigm—in which public child welfare proponents constructed children as a population group in need of comprehensive medical, social, and childcare services, justifying a massive infrastructural expansion—to a problem-focused paradigm, in which expanded resources were increasingly funneled to jurisdiction over a single issue: parental maltreatment of children. My findings demonstrate how administrative trends toward increasing managerial efficiency and problem-focused resource allocation in broader welfare governance influenced shifts in jurisdiction that reshaped child welfare into a maltreatment-focused system. By the mid-to-late 1970s, child welfare actors were either compelled or highly incentivized by new administrative and professional norms to relinquish jurisdiction over most other child welfare issues, funneling expanded resources to investigating parental abuse or neglect of children. In this reframing of the development of child welfare, professional advocates still played an important role in vastly increasing public attention to child maltreatment and advocating for laws that respond to it.[6] Yet they were only one element in the larger story of American child welfare's institutional development as the primary regulators of familial norms.

My historical-institutional account explains an initial three-stage process of institutional development, with long-term implications for the regulation of maternal prenatal behaviors: In the first stage, from 1935-1949, child welfare advocates constructed a target population of children, whose unique needs required specialized rehabilitative services. Successful advocacy for these services during the second stage, 1950-1967, enabled a rapid expansion of infrastructural capacity—expanding child welfare funding and staffing and thus its ability to intervene in families. This expansion enabled increased jurisdiction—with expanded authorization for interventions in specified issues, including poverty and child abuse in the 1960s. Finally, during the third stage, 1968-1980, broader politicized anti-social work sentiments and a new administrative logic of managerial efficiency in social services crippled the once-influential Children's Bureau, reshaping how children's agencies did their work. These new trends converged with nascent child protection advocacy to focus an infrastructurally expanded child welfare system on a much narrower jurisdiction: child maltreatment. As documented in Chapters 4 and 5, the result of this jurisdictional contraction was a "funnel effect," in which a focus on reducing maltreatment risks acted as a mechanism for funneling multiple issues, including poverty and drug use, into a problem of parental inadequacy. Instead of addressing the comprehensive needs of children, as the early advocates for child welfare intended, or even reducing child maltreatment, as later advocates sought, child welfare services turned into a massive surveillance system with uneven outcomes for disproportionately poor and minority families in the late twentieth century. Finally, as described in Chapter 6, the institutionalization of child welfare's expanded surveillance capacity legitimized further expansion of regulatory authority, in the form of state laws mandating interventions in cases of substance-exposed infants.

[6] This reframing also complicates theories of the "social construction" of the problem of child abuse (Cradock 2014; Gelles 1975; Hacking 1991; Nelson 1984). While agenda-driven activism certainly made parental abuse and neglect of children a problem by the 1980s that may have been perceived very differently in the past, these scholarly accounts ignore the influence of infrastructural capacity and broader welfare governance norms that shaped child welfare's focus on child maltreatment.

This new data and analysis contain major implications for both how we understand child welfare development, and our understanding of racial disproportionality in child welfare. First, these findings, guided by a theory of regulatory authority explained below, account for the interactive effects of infrastructural expansion and jurisdictional expansion, and thus more accurately explain the rise of a child welfare system that currently impacts a third of American children (Kim et al. 2017). Moreover, current accounts narrowly focus on developments within child welfare, but this dissertation situates child welfare as part of a larger American welfare system, influenced by broader administrative trends and policy norms. In doing so, it helps explain why the oft-articulated and sincerely intended intentions of child welfare actors to preserve and aid families appeared to have largely backfired by the late twentieth century, with child welfare agencies better equipped to separate families than to preserve them (Reich 2005; Roberts 2002; Wang and Daro 1997: 5).

Second, this data complicates current explanations for racial disproportionality in child welfare. Existing scholarship explains the rise of disproportionate numbers of minorities, especially African Americans, in child welfare interventions as follows: child welfare agencies largely ignored African American children until the 1960s, primarily because that is when social and legal activism led to changes to eligibility for the Aid to Dependent Children (ADC) financial aid program and other federal regulations (especially the Flemming amendment),[7] which meant that more minority children were likely to receive surveillance and interventions (Billingsley 1972; Lawrence-Webb 1997; Raz 2020). Yet I found data (elaborated in Chapter 3) showing that African American children were overrepresented in public child welfare as early as 1945, and that they constituted a disproportionate 30% of child welfare cases by 1959 (Jeter 1960). These confounding factors can be explained, I argue, by reframing the child welfare narrative to focus on the interaction between infrastructural expansion and jurisdiction. My findings indicate that the primary cause for the increasingly disproportionate number of minority children in child welfare services was the expansion of public—as opposed to private—child welfare infrastructure, specifically funding and staffing, as well as public agencies' expanded geographic jurisdiction over urban areas in the 1950s. When private agencies dominated child welfare services prior to the 1940s, they had free reign to ignore children of color, who were in effect overlooked by the dominant actors in the field. In fact, private agencies continued to avoid serving minority families well into the late twentieth century for the relatively smaller proportion of the child population they still serviced (Bernstein 2002). What changed in the 1940s-1960s was the infrastructural growth of specifically *public* child welfare, which served a disproportionate number of African American kids as far back as 1945, the earliest numbers we have available (Jeter 1960). As public agencies' resources expanded, they not only took over some formerly private child welfare arenas, they expanded beyond them, fueled by rising federal and state funding (geared toward public agencies only) to hire more staff and expand their caseloads.[8] As a result, African American children went from suffering from a lack of comprehensive child welfare services to overrepresentation in an increasingly punitive child maltreatment-focused system. The activism-driven discovery of child abuse and changes in

[7] The Flemming amendment outlawed state policies that withheld welfare funds from eligible families with children born to unmarried mothers. Once these policies were banned, a significantly higher number of minority children became eligible for funds.

[8] See Chapter 3 for more details on the infrastructural expansion of public child welfare. Note that in the late 1960s, state agencies began contracting out to private agencies more, but public child welfare agencies remained the dominant actors, especially because states still set eligibility standards for funding.

federal regulations compounded matters, but they are not the key factors—they do not explain the initial growth in African American overrepresentation. In brief, this is a story about infrastructural expansion, as much, if not more, as it is about agenda-drive activism.

I do, however, want to note two important caveats to this finding: First, the findings described above do not necessarily mean that infrastructural capacity was the sole cause of the overrepresentation of African American children at least as far back as the mid-1940s. The data in this dissertation does not show that federal and state actors involved in this infrastructural expansion accounted for race as a motivation, but tensions between public and private agencies, profound racial inequalities in income support and other social welfare policies in the United States, as well as the lack of attention to issues of African American families by private agencies, may have also played a role (Simmons 2020). What this data does establish definitively is that the story of racially unequal outcomes in child welfare well predated broader welfare changes, including the overrepresentation of minorities in public assistance programs, and that infrastructural expansion played a major role in enabling child welfare's disproportionate focus on minority children. Second, there is a large and contentious literature on whether racial disproportionality is due to poverty alone, parental behaviors, lack of appropriate support for poor parents, systemic or individual worker racism, and other reasons (Dettlaff and Boyd 2020; Drake et al. 2011; Lanier et al. 2014; Najdowski and Bernstein 2018; Putnam-Hornstein et al. 2013). My dissertation does not intervene in the complex question of what are the direct and ongoing cause(s) for the racial disproportionality that has dominated the past seven decades of child welfare. Instead, I focus on how infrastructural and jurisdictional shifts legitimized by the state and by professional and public opinion allowed for expanding family interventions, and how such interventions are linked, among other potential factors, to disproportionate outcomes for poor and minority families and long-term outcomes for interventions with substance-exposed infants.

Empirical Contribution II: The Role of Child Welfare in Perinatal Regulation

The dissertation's second empirical contribution is to demonstrate that the institutionalization of child welfare's protective authority catalyzed the expansion of fetal protective policies. Existing scholarship links regulation of drug use during pregnancy to conservative anti-abortion efforts, to medical authority and expertise, or to the racialized criminalization of poverty, conforming to mainstream welfare scholarship on political trends in the 1990s. Yet historical-legal research makes clear that by the 1990s, public and professional opposition had largely doomed criminalization efforts to failure. Instead, both liberal and conservative legislators harnessed child welfare's legitimation as a protective authority, committed to reducing child maltreatment risks. By the early 1990s, state legislators were leveraging the same network of mandated reporters and child welfare agencies that deal with child abuse and neglect to expand fetal protectionist policies. By 1994, twenty-seven states reported that they required medical professionals to report substance-affected newborns to child protective services, with some agencies intervening during pregnancy, trends that continue to this day (Wiese and Daro 1995). That is, while medical professionals are involved in the process of categorizing and reporting SEI cases, the primary authority for intervention rests with child welfare.

This dissertation argues that the transformation of child welfare services from an institution focused primarily on child abuse and neglect helped establish these agencies as a regulatory authority over American mothers, even prior to childbirth. Building on a bipartisan

framing of child welfare agencies as child protectors, both liberal and conservative state legislators expanded child welfare interventions in substance-exposed infant cases, while reframing surveillance and family separation as supportive social services.

This argument contributes to existing literature on perinatal regulation. I argue that by isolating fetal protectionism from larger trends in protectionism for children overall, the literature overlooks a key issue that explains the development of these policies. Factors like anti-abortion advocates and legislators, the war on drugs, and cultural and technological changes are important, but they are not sufficient conditions to explain the rise of these policies. Pre-existing institutions like child welfare agencies, however, are a necessary condition for the growth and expansion of fetal protection in the United States. As their infrastructure expanded and jurisdiction contracted, child welfare agents focused on categorizing and assessing maltreatment risk factors, in an effort to reduce individual social worker bias and improve consistency in decision-making processes. However, as risk assessment instruments became a key tool in child welfare practice, they in effect translated factors like poverty and health issues such as drug use, into indicators of future parental mistreatment of their children, legitimizing child welfare surveillance and interventions.[9] The expansion of child welfare's infrastructural capacity and the legitimation of its surveillance powers (1950-1980) enabled American state legislators to expand professional surveillance of substance-using pregnant women through harnessing the institutionalized protective authority and the available infrastructure of child welfare (1980-2000). After explaining the transformation of child welfare into a maltreatment risk-focused family regulation system (Chapters 3-4), the dissertation presents an analysis of professional discourses of risk related to substance-exposed infants (Chapter 5), two state case studies, and an analysis of all state laws from 1970-2016 (Chapter 6) to demonstrate how state legislators built on pre-existing infrastructural capacity and jurisdictional legitimacy of child welfare agencies to authorize interventions in substance-exposed infants. As a result, the primary American model for regulating motherhood is through social services, which seeks to influence maternal behavior by controlling access to their children.

Theoretical Framing

This dissertation explores the construction and legitimation of regulatory authority in American welfare governance, especially the regulation of families, the primary social unit in American society. To explain this, I provide a theory of regulatory authority, generated as part of the dissertation findings, which provides both an explanation of how regulatory authority is constructed and legitimized in welfare governance, and what the empirical implications of such a framing are for our understanding of American family regulation. As a preface to this theoretical section, I will define some basic terms. Regulatory authority indicates the power of both state and non-state actors to regulate and intervene in social issues affecting specified target populations. I use the term "regulatory authority"—not more common terms like "state power" or "state authority"—because it avoids attributing power to an all-knowing state, and instead acknowledges the hybrid state-civil nature of welfare governance. Non-state regulators are usually professionals or other individuals or organizations with credential-based legitimacy, who are often legitimized and empowered by state laws and resources. Regulatory authority over

[9] While this was due to data that showed greater risk of poor outcomes for children facing poverty and parental drug use, this process did not necessarily involve resources to address those problems.

families in the United States is shared between state and professional actors in a network of agencies that cohere into a loose system that I refer to as "child welfare services."

To explain this theory of regulatory authority, I will first introduce scholarship that explores the question of how state and non-state actors expand and legitimize their authority. I will link these theories to research on specifically American governance development, and I will then present my theory of regulatory authority. Finally, I will describe how this theory builds on and contributes to the existing literature.

Current Literature

How do state and non-state actors legitimize and expand authority over social life? Research on this question can be divided broadly into two schools of thought, both of which focus on state actors. The first is scholarship influenced by Marxist and pluralist thinking, the predominant framing in state theory for much of the middle twentieth century, which views "the state" as a largely empty space in which political and class-based actors battle for control of resources (Skocpol 1985: 4-5). The second, and the one that most influences this dissertation's framework, focuses on a strong state, albeit one with power that is heavily reliant on a state and non-state hybrid of regulators. This perspective can be traced to Weber's insight that the legitimacy of modern state rule over complex economic and social systems is rooted in its authority as an abstracted rational-legal order. In practice, this order is manifested through a strong network of professional state bureaucrats, who both reinforce and diffuse state power in the process of administering it (Weber 1978). Scholars of state theory in the 1980s elaborated on this Weberian framing, explaining state power as a complex hybrid of administrative, legal, bureaucratic, and coercive systems that structure relationships both between civic society and political authorities, as well as within civil society (Skocpol 1985). A different, but similarly state-centered argument is proffered by Bourdieu, who views the state as a largely centralized regulatory power, with multiple forms of "capital" or resources for regulation. In particular, Bourdieu reframes Weberian conceptions of rationalized authority as the state's informational capital, manifested in its control of information, and describes the state's "power of constituting the given" as its symbolic power—or the ability to construct how inhabitants understand their social reality (Bourdieu 1991: 170).

This conception of power as concentrated in the hands of state actors is complicated by Mann's theory of "infrastructural power," in which state actors construct their symbolic power by using the infrastructure of civil society—local agencies, private organizations, civil actors—to implement their vision (Mann 1984, 1993). While some interpreters argue that Mann's concept of infrastructural power is generally top-down (Soifer 2008), others complicate this vision, recognizing a two-way influence between state and civil society (Mann 2008; Weiss 2006). Research on the implementation of state policies reinforces this point, indicating that because the lower-tier actors that implement the state's vision may revise or entirely transform it in the governing process, state symbolic power may be sharply undermined, its authority fragmented across multiple regulators and its policies and ideas largely reimagined (Loveman 2005; Migdal 2001).

While much of this research focuses on implementation of existing state power, Loveman (2005) shows how state actors can legitimize new and expanding authority (i.e. symbolic power) through multiple processes, key among them a heavy reliance on infrastructural power. Loveman describes how states normalize the legitimacy of an unprecedented expansion of social regulation by coopting non-state actors—often bureaucrats, professionals, activists, or others with pre-

existing infrastructural capacity—to impose standardization of new administrative interventions. This insight into how the expansion of state-sanctioned interventions in new populations and spaces unfolds (Loveman 2005), is implemented (Mann 2008; Migdal 2001), and legitimized by a hybrid of state and professional non-state actors (Bourdieu 1991; Canaday 2009; Skocpol 1985; Weber 1978) is key to both understanding American welfare governance and to explaining my theory of regulatory authority.

Regulatory Authority in American Welfare Governance

The theories reviewed above highlight how regulatory power is complex and diffuse, illustrating the importance of professional actors. These actors are imbedded in meso-level networks and organizations that mediate between state policies and the civil society for which the policies are intended, engaging with and often transforming state policymakers' vision in the process of implementing it. My dissertation builds on this insight, seeking to explain how this hybrid state-professional governance enables regulatory actors to expand their authority, especially in the American context. A conception of regulatory authority that integrates state and non-state actors is, in fact, particularly relevant to American social welfare governance. This assumption is supported by existing research that illuminates the impact of professional actors in American state and policy development, as described in this section.

Drawing on the theories of Mann (1984, 1993), Novak argues that the United States has historically been a strong state, not in the conventional sense of centralized despotic power, but in terms of infrastructural power (Mann 1984). That is, federalism and a public-private hybrid of actors that implement policy in the United States have historically allowed laws to be enacted quite rigorously, despite a lack of a centralized government (Novak 2008). These arguments are expanded in scholarship on American political development (APD). Skowronek accounts for the role of meso-level actors in a temporally-sensitive description of the development of American state power. He traces the shift from a decentralized network of local governments, courts, and political parties to a centralized administrative state, highlighting the important role of professionals in this process (Skowronek 1982: 171). As Skowronek shows, lawyers, social scientists, and eventually, a civil service corps of "experts," i.e., bureaucratic professionals, pushed for reform and helped build the sprawling administrative bureaucracy that became core to the American state by the end of the Progressive era. Expanding on this point, Skocpol argues that not only bureaucrats and professionals, but organized social networks and non-profit associations interacted with pre-existing political and institutional structures to shape American policy formation (Skocpol 1992).

While these and other scholars of American political development focus on a wide range of social, economic, and political governance, their insights are particularly applicable to American social welfare governance. American social services—which were strongly linked to regulation of family norms—were decentralized throughout the eighteenth and nineteenth centuries, but the hybrid public-private nature of such services and regulations also meant that it deeply penetrated American social life. Charitable services for poor women and children were linked to strict behavioral norms from colonial times onwards (Abramovitz 1996; Leiby 1978). However, how these services were disbursed and regulated shifted over time. The growth of both a network of lay charitable associations and a professional class in the Progressive era was linked to increasing public-private partnerships across the US, and helped shape an American

administrative state that was both infrastructurally expansive and deeply local and fragmented[10] (Morgan and Campbell 2011).

Infrastructural Expansion and Jurisdictional Contraction: A Theory of Regulatory Authority

My research builds on prior scholarship on the expansion of state authority to argue for a theory of regulatory authority that accounts for the complexities of social welfare governance in the United States. Specifically, it will address both the hybrid nature and infrastructural fragmentation of such governance. To explain this framework, the dissertation deconstructs regulatory authority into its two primary constituent parts: jurisdiction and infrastructural capacity. I define *jurisdiction* as a) the regulatory power of state and state-sanctioned non-state actors to make a specified range of interventions in substantive issues or behaviors, and b) the boundaries of the populations and spaces in which regulators are authorized to intervene. Jurisdiction, however, is only as meaningful as regulators' *infrastructural capacity* to implement interventions in these populations and spaces. Infrastructural capacity indicates the staffing, funding, and the resources—buildings, paperwork, technologies of surveillance—that the funding can buy and staff can employ. Jurisdiction can narrow in terms of interventions authorized, even as infrastructural capacity expands due to the population it can reach or spaces it can control, or vice versa. Based on this more nuanced conception of authority, the dissertation argues for refining our conception of welfare state governance, in order to more clearly understand the authority of those charged with implementing welfare policies, whether state actors or professional proxies with state-sanctioned legitimacy for interventions. Instead of speaking generally of "authority" or "state power," we should consider: what resources do regulatory authorities have to implement policies, what are the substantive legal bounds of their ability to intervene in people's lives, and how do these two factors interact and reshape each other over time?

This dissertation shows that the relationship between infrastructural capacity and jurisdiction is recursive, not causal, with each shaping the other, and each independently influenced by evolving *administrative logics* that shape the values and framings of professional and state administrative actors. Administrative logics are dominant administrative ideologies and values-shaped practices that influence how infrastructural capacity and jurisdiction interact to mediate the long-term effects of policies (Thornton, Ocasio, and Lounsbury 2012; Whiteman et al. 2017). In the case of child welfare, a rehabilitative logic of welfare administration shaped the focus on comprehensive casework-based services for children in the aftermath of the Social Security Act of 1935. By the 1960s, however, scholars describe the rise of what I call an administrative logic of managerial efficiency, which was dismissive of casework services and which transformed agencies throughout the federal government—from housing (Bell 1985) to public assistance (Leiby 1978; Randall 1979; Steensland 2008) and, as this dissertation shows, child welfare.

Administrative logics are built on cultural schemas and integrated into policies through legislative advocacy. Cultural schemas are ideological framings that maintain pervasive and resonant meanings over time, and shape policy feedback processes through discursive and institutional mechanisms (Ferree 2003; Steensland 2006). In one example of such a cultural schema, American policy responses to the poor have often hinged on a concept of deservingness

[10] Note that western charities, such as those located in California, tended to be more publicly run, and less likely to be run by religious charities, as opposed to the east coast (Macallair 2015).

that ultimately holds individuals responsible for structural inequalities that affect them (Katz 2013). While some histories of child welfare attribute the individualizing ethic of modern child welfare to the medical professionals who sought to impose a diagnostic model on child welfare interventions in the 1960s (Nelson 1984; Raz 2020), my dissertation shows that this perspective underestimates how child welfare is shaped by broader American welfare state policies structured by an individualist ideology. Finally, legal advocacy efforts by individuals and organizations seeking to promote policies influenced by particular administrative logics and cultural schemas also shape the co-development of infrastructural and jurisdictional authority.

Contribution to Current Literature

How does a theory of regulatory authority contribute to existing knowledge on the expansion of regulatory authority over social life? And how does it help explain the empirical findings of this dissertation? First, the dissertation findings demonstrate how interacting shifts in infrastructural and jurisdictional capacity are an important factor in transforming how authorities regulate specific populations. This is both a structural and deeply materialist argument: Infrastructural capacity is difficult to fully disassemble—it is hard to shut down a thousand offices spread across the country, governed and funded by a maze of professional, local, state, and federal authorities, and staffed by thousands of employees in physical buildings with widely publicized phone lines that people know to call. This is especially true of the deeply fragmented system of American social welfare governance, where policies and funding are often set on the local level, making systemic and national change particularly challenging. Yet shifts in jurisdictional boundaries can gradually reorient infrastructural resources, which simultaneously can influence how these reorientations unfold. Ultimately, this paper shows how the construction of an infrastructure to support surveillance of a population, even with the most progressive intentions in mind, can enable a redirection of that infrastructure for relatively more punitive jurisdictional purposes.

Such a reorientation may take place decades after the infrastructure was first established, illustrating the power of unintended policy consequences. The concept of unintended policy outcomes is well studied in scholarship on American political development, which describe the path dependent development of policies—often in unexpected ways—as shaped by pre-existing institutional resources and political and social factors (Mittelstadt 2005; Orren and Skowronek 2016; Pierson 2000; Skocpol and Finegold 1982). This dissertation builds on these insights to argue that the effective expansion of regulatory authority requires building on institutionalized state structures that already possess socially legitimate regulatory authority. Such a framing contributes to existing theories by focusing specifically on the interaction between materialist infrastructural factors and a nuanced and clearly defined conception of jurisdiction. In doing so, it moves beyond this scholarship's focus on policy development to examine the regulatory authority that results from such policy changes, especially what populations such authority directly targets; in doing so, this theory emphasizes the key issue of *legitimacy*, which is highlighted in some state theories (Loveman 2005) but under-theorized in American political development scholarship. Specifically, in the case of American welfare governance, expansion of authority requires building on pre-existing infrastructural capacity, as well as the pre-existing

jurisdictional legitimacy of non-state professionals.[11] This dissertation shows this process occurring at two key junctures in the history of child welfare: first, in the narrowing of jurisdiction to focus on child maltreatment (Chapter 3), and second, in the authorization of child welfare agencies as the primary regulators to intervene in cases of substance-exposed infants and their mothers (Chapter 6).

Second, studies of infrastructural power—and of state regulation more broadly—tend to focus on expansion, not contraction, of authority, and thus cannot adequately explain the relationship of infrastructural capacity to such contractions (Mann 1984; Skowronek 1982; Soifer 2008). The theory of regulatory authority in this dissertation specifically highlights how expanding infrastructure can be linked to a narrowing jurisdiction. However, the findings show that the narrowing of jurisdiction does not necessarily minimize its impact, and that contraction does not mean less intensive or even less comprehensive regulation of target populations. Instead, such contraction can have a "funnel effect," in which multiple issues are reframed to fall under the narrowed jurisdiction. In the case of child welfare governance, I show that the main mechanism for the funnel effect is risk regulation, in which efforts to reduce risk of unwanted outcomes—maltreatment in the case of child welfare—act as a mechanism for expanding surveillance and legitimizing interventions into multiple issues that are only indirectly linked to harm to children. For child welfare, the expansion of risk regulation meant that multiple risk factors for poor child outcomes, from parental health problems and drug use to poverty, were included in efforts at maltreatment prevention, funneling these issues into child welfare's jurisdiction. This was the result not only of child welfare's focus on risk prevention, but also of broader welfare governance trends toward resource reduction, as well as the availability of a child welfare infrastructure to address them, even if they did not have the resources to do so effectively.

An administrative logic that emphasized efficiency over comprehensive and rehabilitative services contributed to the redirection of resources away from discrete needs and toward eliminating distinctions between these needs. The effect was the translation of risk factors, often linked to structural inequalities in healthcare access and economic status, into parental inadequacies that justify protective interventions for children. In this paradigm, parents are perpetually viewed as potential abusers of their children, not as part of a deeply bonded family unit with their children; child safety, not family preservation, is the paramount concern. To be very clear, this professional shift was enabled and reinforced by broader welfare governance trends. The data shows that many individual social workers and child welfare advocacy organizations strongly sought to support and preserve families, yet they fought a losing battle against broader structural trends, such as better funding for child removal than for family preservation, a massive research publishing industry on parental harms to children, and broader welfare governance norms that held individual parents responsible for the effects of structural inequalities (see Chapter 4). Throughout this period of 1960 to 2000, federal and state legislators expanded resources for child removal and passed laws mandating and expanding professional reporting of suspected child maltreatment to child welfare authority, while researchers developed increasingly sophisticated risk assessment instruments, together incentivizing a risk and maltreatment-focused paradigm of child protection. These trends also increased child welfare

[11] This framing moves beyond questions of cultural versus structural factors as the primary causal mechanisms for policy change (Steensland 2006), highlighting instead how tightly integrated both cultural and material and structural elements are in the development of regulatory authority.

agencies' legitimacy as child protectors, sanctioned to protect children from parental problems, yet with fewer resources to assist parents in mitigating those problems. That is, child welfare agencies were given increasing jurisdiction over the problem of child maltreatment—and by extension, the main social, medical, and financial problems that contribute to it. Yet they were not empowered with resources to effectively respond to that problem. Ultimately, this dissertation demonstrates how child welfare's expanding infrastructural capacity and contracting jurisdiction shaped their legitimacy to manage an increasing range of state-sanctioned interventions in disproportionately poor and minority American families, eventually extending to perinatal regulation.

Third and finally, the concept of regulatory authority in welfare governance expands Mann's conception of infrastructural power. By focusing on the interaction between infrastructural and jurisdictional development, I move beyond viewing infrastructure as a tool—or expression—of state power (Mann 1984; Soifer 2008), and toward a conceptualization of infrastructural capacity as one element in the development of a broader, multi-level, state-civic hybrid of regulatory authority. This framing highlights the interaction between infrastructural capacity and jurisdiction, influenced by a variety of factors and implemented by multiple actors drawn from a mix of civil society and state, resulting in a multi-layered network of governance. This argument also goes beyond Campbell and Morgan's arguments for the fundamentally hybrid nature of American social welfare governance, which focuses broadly on how public and private actors work together (Morgan and Campbell 2011). My dissertation portrays a more complex interaction of multiple levels of public governance interacting with what I call meso-level institutions, which include both professional actors like medical and social work practitioners, some of whom move fluidly between public and private institutions, as well as the organizations that represent these actors.

The development of regulatory authority in social welfare governance—and the impact on families—is linked to the interaction of these influential professional organizations and networks with the particularly federalist structure of American state authority. American regulation of the family operates in three overlapping realms of authority: 1) Federal polices and funding; 2) State and local (county or municipal) policies and funding; 3) Meso-level institutions, specifically medical professional and social work professional organizations and networks, as well as private non-profit organizations involved in implementation of social service policies. This ordering of realms does not, however, translate into a centralized and downward direction of power, in which the federal policies set state and county policies, which, in turn, shape private and professional institutions that implement these policies. In fact, meso-level institutions often drive changes in state and even federal policies, and institutional implementation processes may completely transform the way policies are actually experienced by the individuals they target (Migdal 2001; White 2013). Most importantly, the particular paths by which these institutions have developed over time shapes how policies they implement develop as well.

The effect of this multi-layered form of governance supports significant research by sociologists of the state and the law, who argue that the process of implementation can transform state policies, sometimes into an entirely different result than intended (Ewick and Silbey 1998; Migdal 2001). Unexpected outcomes are not necessarily aberrations or a sign of weak state power; instead, the fragmented outcomes of state policy implementation are in fact constitutive

of state power, particularly in the United States (Clemens 2006; Novak 2008).[12] That is, the face of state power, particularly for issues like family policies, are the institutions that implement the policies. Those institutions, which are characterized by diverse goals and complex bureaucracies, do not simply reflect a centralized state agenda, but actively reshape national agency agendas into a fragmented and often inconsistent loosely connected set of policy norms. In an illustration how implementation changes state vision, the purpose of early maltreatment-focused legislation on both the federal and state levels was specifically to reduce the cases of child maltreatment. But throughout the 1980s and 1990s, the number of cases increased, despite increased federal and state funding for prevention and response, (albeit funding that disproportionately focused on child removal as a response). Ultimately, as I show, the implementation of these policies through an increasing focus on risk-based surveillance and massive mandated reporting requirements funneled other issues, including poverty and health problems, into an expanding maltreatment processing system.[13]

Methods

This section provides a brief overview of the methods and analysis used in this dissertation. For a detailed description, please see the methodological appendix at the end of this dissertation. My dissertation combines archival research with content analysis of historical professional journals, supplemented by purposive interviewing. To answer questions about national trends in child welfare (1935-2000)— trends in infrastructural resources (growth and decline), what populations were most affected, and what issues were most important to child welfare policy leaders like the Children's Bureau—I conducted archival research in the National Archives and Records Administration (NARA) in College Park, MD, and federal depositories in academic libraries (University of California, Berkeley, Princeton University, and University of Pennsylvania); I also made extensive use of Hathitrust.org's online archival resources, particularly in 2020, when the Covid-19 pandemic shut down in-person library and archival access. As part of this process, I interviewed seven individuals involved in national child welfare efforts and national survey construction from the 1970s to the 1990s, in order to clarify and triangulate my analysis of written documents.

To track national trends in child welfare discourses and practices—what topics were most important, how were issues like poverty, maltreatment, and race addressed, and other questions related to implementation of policies—I conducted in-depth qualitative and quantitative analysis of 1,923 articles in the landmark *Child Welfare* journal (1950-1990), aided by a team of undergraduate researchers. I also conducted additional analyses of child welfare journals on the development of risk assessment tools from 1978-2000, as well as a cross-disciplinary analysis of medical, social work, public health, and legal journal articles on how risk of substance-exposed infants was understood and what practices were linked to it from 1978-2000. For my journal

[12] Clemens argues that the American "delegated" and decentralized state is not an accident of political development, but was intended by those who believed in its merits (Clemens 2006). My analysis of American governmentality goes beyond decentralization to examine the ways in which authority is constructed in American society as a result of fragmented governance.

[13] Note that some argue that child welfare interventions are one of several factors that have helped reduce rates of child neglect and abuse in the 1990s and early 2000s (Finkelhor and Jones 2006). Others debate this, arguing that such interventions have penalized poor parents of color for issues largely beyond their control (Fong 2020; Lindsey 2004; Reich 2005).

content analysis approach, I co-developed a method to both quantitatively and qualitatively analyze large-scale textual data (Lichtenstein and Rucks-Ahidiana 2020).

Finally, I sought data that would help explain the development of child welfare authority in the regulation of substance-exposed infants and their mothers. I began with a legal analysis of all state laws related to substance-exposed infants from 1970-2016. I then selected state case studies that represent one of the two approaches that I found exist among states: the first and by far most common approach is to assign authority primarily to child welfare services (which I examined through a case study of California), while the second is a much more severe and less common approach, civil commitment (which I examined through a study of Wisconsin), which tends to combine both child welfare and medical and other authorities.[14] (See dissertation overview section below for more on state case selection.) For data analysis of state case studies, I conducted historical legal research in the California State Archives in Sacramento and the microfilm legal archives in the University of California, Berkeley Law school. I also used online legal resources in Westlaw and Wisconsin legislative and administrative archives for further research. I supplemented legal and historical documentary research with eight purposive interviews of lawyers and child welfare administrators active from 1960 to the present in California and Wisconsin.

Dissertation Overview

The empirical argument in this dissertation begins with a brief historical overview of American social welfare (Chapter 2). The overview explains the evolution of the fragmented, multi-level governance of American social services in the nineteenth and early twentieth centuries, a form of governance that involved both state and non-state actors and shaped the development of welfare professionalization. It also provides important context about the rise of American social work and the casework method, which deeply influenced the professional development of child welfare in the twentieth century. This information lays the background for the remaining empirical chapters of the dissertation, by demonstrating how the fragmented governance of American social services, influenced by schemas of deservingness and protectionism, enabled the development of a widespread infrastructure of child welfare agencies that grew increasingly focused on child protection.

The third chapter of my dissertation demonstrates how infrastructural expansion and jurisdictional contraction reshaped child welfare into a system focused on child maltreatment. Existing research roots the expansion of child welfare in the "rediscovery of child abuse" as a social issue in the 1960s. Integrating archival and reconstructed historical survey data, I provide an alternative account: In the 1940s and 1950s, child welfare advocates sought to construct children as a population in need of a wide array of specialized rehabilitative services, a framing that helped them rapidly expand child welfare infrastructure. By the late 1960s, the growing dominance of an administrative logic of managerial efficiency in welfare governance narrowed child welfare's jurisdiction to clearly defined "hard services" with measurable outcomes, like foster care and adoption. These shifts converged with increased reports of child abuse in the 1970s-1980s, reorienting a now vastly expanded child welfare infrastructure to narrowly surveil mostly poor and disproportionately minority families for parental inadequacies.

[14] A third approach is criminalization, but that predominates in only two states, South Carolina and Alabama, both of which have been covered by other literature in relative depth (Amnesty International 2017; Howard 2017; Lewis 2016).

The fourth chapter explores the impact of this shift: the development of a widespread surveillance system predicated on risk assessment and mandated reporting. I draw on historical conference materials, child maltreatment surveys, legal data, and analysis of professional literatures (1978-2000) to show how child welfare professionals became increasingly concerned with assessing and mitigating risk of child maltreatment. Risk-assessment instruments designated parental income, marital status, and health issues as risk factors, funneling these issues into a narrow paradigm of child maltreatment. These instruments, combined with much higher funding for child removal than for family preservation, incentivized—in effect, mandated—even the most well-intended child welfare agents to recast the outcomes of structural inequalities as evidence of potential child maltreatment. Simultaneously, a growing number of state laws required that professionals report even suspicions of abuse, transforming child welfare into a multi-organizational system, in which other professions—medical employees, domestic violence counselors, financial aid workers—act as arms of child welfare, surveilling, assessing risk, and reporting families for interventions. The combination of mandated reporting requirements and widespread use of risk assessment instruments functioned as a funnel effect, drawing multiple issues into the jurisdictionally contracted purview of child welfare over child maltreatment.

The fifth chapter focuses on how pervasive risk reduction discourses framed the substance-exposed infant as a paradigmatic case of a child who was not necessarily harmed but seen as "at risk" for future harm. I analyze medical and social work (including child welfare specific) journal articles, sampled from professional journals published between 1978 and 2000, which focused on the issue of substance-exposed infants. The findings of this analysis show two different paradigms of risk in each field, which are linked, in turn to two different and distinct paradigms of authority. While medical authors tend to focus on direct, short-term risks of substance use and advocate for a consensual and advisory authority role, social workers tend to focus on long-term correlated risks of substance use. These indirect risks, in turn, are linked to a multi-professional (social workers, legal and medical professionals, and legislators') justification of increased surveillance by child welfare agents, as well as a coercive form of authority, predicated on their ability to remove children. These findings demonstrate not only the development of a new area of child welfare jurisdiction over prenatal behavior, but how a new paradigm of risk-focused family regulation enabled an expansion of child welfare authority into the womb, funneling broader issues of health and poverty into a jurisdictionally contracted but deeply pervasive surveillance of parental behavior. This analysis provides the necessary background to the next chapter, which demonstrates how child welfare's distinctive brand of authority—a mix of supportive and coercive regulatory powers—became increasingly viewed as a useful alternative to criminalization in cases of prenatal substance use, legitimizing an expansion of child welfare regulatory authority over substance-exposed infants and their mothers.

In the sixth and final empirical chapter of my dissertation, I use legislative data and case studies of California and Wisconsin to show how state legislatures rejected criminalization measures and instead authorized child welfare interventions in substance-exposed infants. Laws related to prenatal substance exposure, much like other policies in the fragmented federalist polity of the United States, were first developed at the state level before federal policy was established on the issue. An analysis of the legal development of state laws shows that legislatures struggled with which profession to authorize as the primary regulators of this issue, wavering between the following four policy responses—criminalization, and three types of civil regulation: civil commitment, social and child welfare services, or medical services. I show that

criminalization largely failed, and medical services were largely demoted to a secondary response, with social services, primarily child welfare, the predominant policy response. To explain the variation in state responses, I chose representative states that developed two types of civil regulation approaches: the most common one, child welfare, represented by California, and the less common approach of civil commitment, represented by Wisconsin, which is the state that most publicly enforces this response, though it is technically legal in many others. I show how in both policy responses, child welfare's coupling of protective and coercive power played an important role. Specifically, the institutionalization of child welfare's protective function obscured the brute power of child removal that underlies its coercive authority, enabling legislators to expand what they framed as supportive interventions pregnant and postpartum women's behaviors. Child welfare's institutionalization as the designated authority over substance-exposed infants illustrates how a sprawling infrastructure of social workers and mandated professional reporters funnel a wide range of multi-disciplinary issues—drug disorders, domestic violence, and poverty—into a problem of parental maltreatment, addressed by interventions predicated on the threat of child removal.

CHAPTER 2. HISTORICAL OVERVIEW

Introduction

This historical overview describes the development of American social welfare governance from the colonial era through the Social Security Act of 1935. The overview contributes to the dissertation in two key ways: first, it establishes some of the key arguments regarding hybrid governance made in the introduction—that American social services were deeply fragmented and decentralized from their origins, but that they still imposed strong and pervasive family regulation. Centralization unfolded slowly, with significant input from meso-level institutional actors, especially professional organizations, culminating in the construction of a strong but still messy and fragmented administrative state by the 1920s. Second, the historical data in this interview demonstrates how social work developed a professional focus on the casework method that came to define the field and in turn shaped child welfare's professional development. As part of this process of social work and child welfare professional evolution, cultural schemas of child protectionism and the relative deservingness of poor families heavily influenced the evolution of both private and public social services. All of this sets the background for child welfare's evolution from a sub-specialty of social work into its own field in the aftermath of the Social Security Act. The lingering cultural and policy traces of casework, deservingness, and protectionism shaped child welfare's development, in the context of a fragmented, decentralized American welfare state that nonetheless wields strong regulatory authority over its most marginalized subjects.

Family and Poverty Regulation

From its earliest roots in the colonial era, American poverty relief efforts were deeply decentralized, based on local networks, and strongly linked to maintaining a gendered family ethic. The new American republic's shift to industrialization and a wage-based economy in the early nineteenth century, however, rattled traditional family norms. Women were more likely to work outside of a family setting, in a factory or on an industrial farm. Men might leave their families in search of jobs or new frontiers, deserting their wives and children and leading to a rise in single-parent homes and, relatedly, a significant rise in poverty rates (Abramowitz 1996). In response to this, social reformers founded a series of neighborhood-based charitable organizations, inspired by a European model that stressed "friendly home visitors" to poor families. These visitors investigated living conditions, provided moral advice, and took applications for aid to the communal charitable organizations they represented (Lubove 1965: 1-5). This model of social services incorporated a strong element of family regulation, with parental behavior often linked to eligibility for aid, indicating how even a deeply fragmented and localized system of social governance could powerfully control the lives of the indigent and marginalized.

With the industrial era, social regulation grew incrementally more centralized. The growth of factories and industrial production was accompanied by poorhouses modeled on the English style. While some poorhouses or almshouses had existed as far back as the 1600s, they began to steadily rise in number during the 1800s. The idea of institutionalization, or "indoor relief," was strongly influenced by industrial values such as standardization and quantification. It was promoted by a variety of advocates, but especially social reformers who saw the changes in family norms as a crisis in the American family, one defined by the often conflated issues of financial dependency and family disintegration—both issues that could be resolved through

inculcating the poor with proper values of industry and high moral standards. Such inculcation, many reformers believed, could only happen in a restrictive and all-encompassing setting such as a poorhouse (Trattner 1999). These developments reflect both continuing cultural schemas of deservingness and need for rehabilitation of the poor, as well as the early seeds of "scientific charity," which was key to the later professionalization of social services, in which scientific and data driven approaches predominate.

All this unfolded during a period of evolution in American family law. In 1838, the Pennsylvania Supreme Court argued, famously, for the "*parens patriae*" doctrine, rooted in British common law, in which the state is justified in removing children from 'improper' homes (Ex Parte Crouse 1838). This principle established that under some conditions—usually extreme poverty or neglect—the state could serve as a superior authority to families. While family integrity and parental autonomy remained important values in the judicial system and as social norms, *parens patriae* formed the legal basis of later interventions in family homes.

Hybrid Governance: The Seeds of American Social Regulation

The period of the 1860s to the 1890s saw three major changes in social welfare: the organization of relief shifted from discrete communal organizations into a loose network of charitable institutions strongly influenced by ideas of "scientific charity," an increasing focus on children, and a shift to a public-private partnership in funding charitable efforts. Together the changes helped lay the groundwork of the professionalization of social welfare and poverty relief, while also establishing early concepts of child protection. These developments also highlight the importance of meso-level organizational actors who gradually began to work with public state organizations.

By the 1860s, efforts at poverty relief were relatively well organized and fundamentally linked to notions of social order that shaped the enforcement of family norms. The American Social Science Association was founded in 1865 to discuss "the relief… of the poor, …discipline of persons, the … treatment of the insane…" (Leiby 1978; Trattner 1999). Many states had established state boards of charity,[15] which oversaw the many charities, institutions, and prisons in their region, and in 1874, the secretaries of the state boards founded the National Conference on Charities and Corrections (the predecessor to the twentieth century National Conference on Social Welfare) to discuss common challenges (Leiby 1978). Intensified relief organization efforts arose in response to the rising immigration, industrialization, and urbanization of the era, which was linked to a growth in poverty that the old methods of reform seemed inadequate to address. Many charitable organizations during this time were influenced by principles of "scientific charity"— a data driven approach to reducing poverty, largely through institutionalization. During this period, social reformers—those influenced by scientific charity and those who resisted them—expanded pre-existing institutions, including poorhouses, orphanages, and friendly visitor systems. This period saw a rise not only in poorhouses and orphanages, which grew from 75 in 1860 to 600 by 1890 (Abramovitz 1996), but also in other institutions of relief, including homes for the blind, reform schools for delinquent children, lodging homes for street children, industrial schools, and forced emigration of some 90,000

[15] For more on these boards of charity, see https://socialwelfare.library.vcu.edu/eras/civil-war-reconstruction/state-boards-of-charity-early-history/, accessed June 11, 2021. The data presented here is originally sourced from the "Official Proceedings of the Annual Meeting: 1893, National Conference on Social Welfare," pp. 33-54, which can be found at this link: http://www.hti.umich.edu/n/ncosw/, accessed June 11, 2021.

children from poor homes on the east coast to mostly midwestern homes (Katz 1996). This rapid development of organized relief represented a new stage in American social welfare. While charities were still usually locally based, their organizers were now part of a cross-continental network, which helped reinforce a traditional ethic of gendered family roles and a stronger emphasis on productivity, across a complex and loosely linked infrastructure of social regulation (Abramovitz 1996).

The rapid rise of children-focused organizations promoted an increasingly pervasive idea of child protectionism. The many new institutions for children reflected a growing emphasis on the idea that children constituted a uniquely vulnerable population, deserving of greater compassion than their poverty-stricken adult caregivers, and that they must be retrained to rid them of any hereditary or learned moral failings associated with their parents' poverty. These ideas found expression in laws like the New York Children's Act in 1875. The Children's Act, passed by state legislators concerned for the well-being of children in often oppressive poorhouse institutions, ordered all children (aged 2-16) out of poorhouses, where some of them lived with their families, and into children-only institutions. The growth of these children-focused institutions led to another shift: increasing public funds handed over to the private, often religious, groups running them (Katz 1996). This public-private partnership was at the core of how the American state regulated the American family: indirectly, through the infrastructure of civil society.

In context of a rising interest in protecting children, the 1870s saw the establishment of Societies for the Prevention of Cruelty of Children (SPCC), partially inspired by lurid newspaper accounts of parental cruelty. The New York SPCC was particularly emphatic in claiming that protection of children from adult "cruelists" was a separate matter from poverty. Yet the first proceedings of their meeting in 1876 indicates that the majority of their cases were of children who had been caught begging, indicating the conflation of poverty and family regulation,[16] (NYSPCC 1876), a theme that would persist throughout the history of welfare services, to this present day.

SPCCs, although formally private organizations, were often linked to the state, in keeping with the increasingly common hybridity of social welfare regulation. Much like other charitable organizations, many SPCCs received significant funding from local governments (Sealander 2003: 57). By the late 1800s and early 1900s, SPCC members in New York formed partnerships with law enforcement (Costin et al. 1996) to ensure that middle-class heteronormative standards of childrearing prevailed in the largely immigrant poor neighborhoods (Miller 1998), and, later, to advocate in courtrooms for standards of sexual behavior, such as statutory rape, that promoted a concept of children and teenagers as asexual, infantile beings, incapable of consent (Robertson 2005). The work of the SPCCs across the country helped achieve two ends: 1) It created the category of parental neglect as an issue separate from poverty, as opposed to previous views, which had seen them as largely interchangeable. This allowed the SPCCs to hold parents individually responsible for the conditions in which they raised their children, in part by linking (with varying degrees of justification) poor child-rearing conditions and bad intentions and hereditary or learned negative behaviors. Such an approach lay the groundwork for an individualist framing in American family and poverty governance, a framing that avoids grappling with structural inequalities. 2) It raised public awareness of parental abuse, which had

[16] See the New York Society for the Prevention of Cruelty to Children. 1876. *First Annual Report, 1876*.

previously been seen as a private issue that should not, other than in the most extreme circumstances, involve state intervention.

By the late 1890s, some charitable organizations began questioning scientific charity principles. A number of actors involved in social welfare also began voicing strong opposition to the institutionalization of children, promoting instead family preservation, at least in theory, although in practice this often meant placement of poor or delinquent children in cottage homes or foster care (Leiby 1978). At the turn of the twentieth century, even as reformers and state officials exhorted the value of family, they broadly accepted that the state and its regulatory partners had the authority to decide the worthiness of any particular family. The legitimation of state authority to intervene in families was crucial to the development of social work, and, later, the child welfare field, as professions.

Social Work and the Sacralization of Children

By the early twentieth century, a sprawling network of organizations and institutions, funded and administered by a mixture of private and state agencies, regulated family norms. The federal administrative state was taking fragmented shape at this time (Skowronek 1982), but did not wield any direct regulatory power over families or poverty relief, which remained regulated by local and state organizations. The exact contours of welfare and family regulation varied by region and state, with western states more likely to rely on state institutions, while eastern states relied on a mixture of private and public institutions (Macallair 2015).

Institutions regulating mostly poor families included local poverty relief programs, orphanages, "placing out" child protective agencies, reformatory schools, and juvenile justice courts. Settlement houses in major urban areas provided services to the poor while conducting research to advocate for broader social reforms (Leiby 1978). Middle and upper class Americans were also experiencing changes, as the growth of compulsory schooling laws—which existed in 32 states by 1900—reshaped child-rearing norms (Katz 1996). Combined with decades-long agitation against child labor, education laws led to an increasing perception of children as "economically useless and emotionally priceless" (Zelizer 1985).

This view intensified in the early twentieth century. Advocates for the poor and for the young successfully battled for major changes that increasingly "sacralized" children. These included: the 1912 establishment of the Children's Bureau, a federal agency dedicated to child welfare, which from its origins and through the 1960s, was deeply influential in spreading norms of childrearing and assisting social workers who worked in child and family welfare (Lindenmeyer 1997); Children's Codes[17] beginning in 1911 (Costin et al. 1996: 83); the passage of mother's pensions—payments for primarily white widowed women that began in 1911 and grew to 39 states (as well as Alaska and Hawaii) by 1919 (Clemens 1993; Skocpol 1992). These mothers' pensions, however, invited the same surveillance that poor families had experienced since the poor laws of the colonial eras, albeit in a new form: local governments that dispensed the aid might send agents to observe families and enforce certain behavioral norms (Katz 1996).

Such policies were promoted not just by the loosely organized network of "concerned citizens" that had dominated social relief efforts in the nineteenth century, but by people who were invested in professionalizing and clearly defining the field of social welfare. Professionalization unfolded through the standardization of rules and policies for social work, as

[17] Children's Codes were catalogues of state-specific legislation affecting children; these codes were used to help develop child welfare resources and advance child protection laws.

taught first in training programs in 1890s and then formal schools of social work, which existed in five major cities by 1910 (Popple 2018; Trattner 1999). World War One was a major catalyst in the professionalization of the field, as social workers were drawn into efforts to aid not just the low-status poor, but higher status American soldiers, through providing psychological services (Ehrenreich 1985).

Despite these efforts, professionalization was a struggle. Social workers, especially in lower tier work, were primarily women (already lower status) who worked with low-status clients. To professionalize, social work leaders had to define their profession and had to specify a set of skills unique to them. By the 1920s, after significant discussion in social work conferences and written publications, this dilemma was largely resolved, with social work focusing primarily on individualized casework, based on a diagnostic method that was strongly influenced by psychoanalytic theories. This focus meant a shift away from larger social reform issues like poverty, and toward the development of an organized, if conflicted, professional field that emphasized individualized well-being. Examples of social work now included medical advising in hospitals and "children's guidance" clinics, which was also appealing to the middle class (Ehrenreich 1985: 76, 119).[18]

This multifaceted trend toward professionalization meant that more women (and it was overwhelmingly women) who were interested in a professional career could find employment in frequently understaffed social welfare agencies. Volunteers were increasingly replaced by professional and often poorly paid employees of such agencies, and associations to assist with social work networking, employment, and education flourished in the early 1920s (Lubove 1965: 119, 129). With a focus on psychiatric well-being, medical social welfare (Lubove 1965), as well as economic relief, conceptions of child protection shifted in social work publications and professional work. Professional journals now often discussed the "dependent" and "neglected" child, which could imply emotional or financial neglect, as well as abuse or physical neglect (Costin et al. 1996: 87-99; Sealander 2003: 60).

By the mid-1920s, SPCCs were experiencing a decline from their height of 346 organizations in 1911-1912 (Costin et al. 1996: 92; Sealander 2003: 60), in the face of a social welfare field that had fragmented over multiple areas of interest.[19] The Great Depression reinforced this change, as it dramatically increased social work's focus on economic relief. The creation of federally funded poverty relief programs, especially the passage of the Social Security Act's Aid to Dependent Children (ADC), more than doubled the number of social workers.[20] Reinforcing this shift to a state and federally dominated social welfare field, in the early years of federal relief programs in the 1930s, administrative laws only allowed public (i.e., state or local government) agencies to receive public money, essentially locking private and religious agencies out of much of the available welfare funding (Morgan and Campbell 2011). In

[18] Kunzel (1995) also argues that professionalization of social work was built in part on their work with single mothers of "illegitimate children." Such women may have previously been cared for by Evangelical women who were part of the "maternity home" movement, and who viewed them as "fallen women" in need of compassionate aid. As social workers took over treatment of the needy, Kunzel argues that they also pathologized these women into sexual deviants or "feeble-minded" women in need of their professional aid (Kunzel 1995). In the process, social workers established their professional expertise in interventions in familial norms.

[19] Other factors may have also played a role, including the decline of feminism and the settlement movement (Costin, et al. 1996), economic factors, and the decline in immigration (Sealander 2003).

[20] The U.S. Census of 1930, the first to count social welfare workers as a distinct category, found 31,000 of them, a number that more than doubled to 69,677 by 1940 (Popple 2018). This huge leap in numbers was linked to a massive growth in economic relief organizations that hired social welfare workers as employees.

this process, child welfare in particular became a profession increasingly dominated by state agencies, with half of state welfare departments incorporating a child welfare division by 1935 (Myers 2006: 72).

Overwhelmingly, even as social work organizational leaders and researchers maintained a focus on child protection and on psychoanalytic and casework training (Anderson 1989: 233), a growing number of social welfare workers were occupied with financial relief.[21] Yet despite the relatively few social workers focused on family and child welfare, children's issues, especially a protectionist ideal that saw children's needs as uniquely deserving of social resources, remained important in both social welfare governance and in American society at large. This was partially due to the arguably most important actor in children's services at the time: the Children's Bureau. A federal agency established in 1912 with a mandate to exclusively focus on child welfare, the Children's Bureau was staffed by research-focused social workers, who advocated widely for children's issues at the federal level and promoted awareness of problems ranging from infant mortality to child labor and childhood illnesses through publications sent to state and welfare agencies across the nation.

As described in Chapter 3, the passage of the Social Security Act helped catalyze a massive growth in social work, and by extension family and children's services and financial aid. By the 1940s, however, family regulation efforts focused on family preservation, reinforced by the Social Security Act's focus on assisting poor children (Frame 1999: 221). By the 1950s, social welfare services for child protection were targeted at families in their home, in avoidance of family break up (Anderson 1989), but child removals still frequently occurred, due to a wide variety of reasons, many linked to financial need (Bernstein 1966; Jeter 1960; Phillips, Haring, and Shyne 1972). Institutions and foster care remained a dominant issue for child welfare workers, particularly in private agencies, but also in public, state-funded agencies, for whom the majority of services still focused on out-of-home care (Jeter 1963). Regulation of familial norms focused increasingly on women's behavior,[22] with social services oriented toward financial relief or services for disabled, neglected, or crippled children (Abramovitz 1996). By the 1940s, a fragmented network of understaffed public and private local child welfare agencies in the 1930s and 1940s focused on a wide range of needs for children, their agenda shaped in particular by Children's Bureau publications and guidance,

[21] While some agencies and organizations questioned this shift from healing individuals via psychological methods to largely administering financial relief, the change was not as dramatic as some scholars have argued (Costin et al. 1996; Nelson 1984). Social work had been shifting to an individual casework method and away from structural social reform for close to two decades by then. Narrowing the focus from solving individuals' psychological and economic problems to primarily solving individuals' economic problems was not a dramatic shift.

[22] Such regulation included "suitable home" clauses, in which welfare agents withdrew support if they found any evidence that the mothers of eligible children had relationships with men.

CHAPTER 3. POPULATION TO PROBLEM: AMERICAN CHILD WELFARE (1935-1980)

Introduction

A review of child welfare journals and publications in the 1940s and 1950s reveals a profession focused on a wide range of issues, including children's medical health, adoption, childrearing norms, juvenile delinquency, and infant mortality. By the early 1980s, a similar review would reveal that child welfare agencies were overwhelmingly focused on one issue: child maltreatment. How did this shift unfold?

Existing research largely ignores the 1935-1959 period of child welfare in the United States; instead, historical accounts root modern American child welfare in the "rediscovery of child abuse" as a social issue in the 1960s. These accounts credit advocacy efforts by non-profit and medical professionals for drawing attention to parental maltreatment of children, thereby fueling the media coverage and the consequent passage of state and national laws that led to the rise of a national system of child welfare as child protection (Costin et al. 1996; Lindsey 2004; Nelson 1984).

This framing is deeply problematized by the findings presented in this chapter. Historical claims that maltreatment was "rediscovered" in the 1960s, after decades of being ignored by social workers, are belied by primary sources presented below, which make clear that child maltreatment was a significant issue for social workers in the 1940s and 1950s. Drawing on archival, professional, and legal data, this chapter presents a new historical-institutionalist account illustrating that child welfare administrators first constructed a population-focused paradigm—in which proponents constructed children as a population group in need of comprehensive services, justifying a massive infrastructural expansion—and then shifted to a problem-focused paradigm, in which those expanded resources were increasingly funneled to jurisdiction over primarily one issue: child maltreatment, meaning parental abuse or neglect of children. This population-to-problem transformation unfolded through a three-stage process, each of which is described in detail below.

The findings described in this chapter explicate the dissertation's framing theory of regulatory authority. A population-to-problem account of child welfare's transformation demonstrates the complex and recursive relationship between regulatory actors' jurisdiction—the specific issues, populations, and spaces in which they can intervene—and the infrastructural capacity that enables these interventions. It also demonstrates the impact of administrative logics, which, influenced by cultural schemas and legislative advocacy, can reshape and reorient pre-existing infrastructural resources to new foci. This chapter's findings shed new light on the rise of modern American child welfare and provide important insights on why poor and minority families have historically been overrepresented in child welfare. Most fundamentally, the findings confound the current narrative in child welfare historical research, showing that child welfare agencies and employees did not "rediscover" child abuse; instead, they relinquished—sometimes willingly and more often quite unwillingly—jurisdiction over most other child welfare issues, including poverty, health issues, and education. These shifts transformed child welfare into an infrastructurally expanded but jurisdictionally contracted system, laying the groundwork for a funnel effect that, as I show in later chapters, transformed a wide variety of issues into a problem of parental inadequacy.

From Population to Problem

The expansion of the American welfare state lay the groundwork for child welfare leaders' successful advocacy efforts to expand their field's infrastructural capacity. Section I below describes how funding incentives and child welfare administrative decisions linked to the Social Security Act (1935) motivated an orientation of the embryonic child welfare system toward a focus on serving the needs of children as a target population. Section II then demonstrates how this orientation was used to successfully legitimize claims for resources that would expand child welfare's infrastructure and jurisdiction over urban, poor, and maltreated children. Finally, Section III shows how administrative and political shifts reoriented an expanded infrastructure to focus on a narrowed jurisdiction, with a primary focus on parental maltreatment of children.

I. 1935-1950: Child Welfare Expansion and the New Population Paradigm

In the early twentieth century, child welfare was a small sub-field of a larger social work profession. Child welfare agencies, many of them privately run by religious or volunteer organizations and most of them concentrated in urban areas, provided a range of family and children's services, from foster care and economic relief to counseling for families and children. The most influential child welfare organization during the first decades of the twentieth century was the Children's Bureau, the only federal agency devoted to "all matters pertaining to the welfare of children" (Families et al. 2013). As part of the Labor Department until 1946, the Children's Bureau wielded significant influence on federal policies related to family and child welfare. Its widespread advocacy and publications also meant that it influenced child welfare agencies and advocacy organizations on the ground. Devoted to research-based advocacy on issues ranging from child labor to infant mortality, the Bureau was relatively less focused on reducing child poverty than other issues in its early decades, despite its advocacy for mother's pensions, which applied only to a small subset of needy mothers (Lindenmeyer 1997: 162).

During the financially lean years of the early 1930s, however, the Children's Bureau leadership was deeply involved in drafting legislation for the first national program for financial aid to poor children. This eventually became the basis for the children and family aid programs in the Social Security Act (SSA) of 1935. As the agency responsible for dispensing millions of dollars in newly available funds from the nation's first centralized programs for family and child poverty, the Children's Bureau's budget and influence greatly increased in the late 1930s (Lindenmeyer 1997: 183, 193-194), as the landscape of social welfare shifted dramatically as a result of the SSA.

The Social Security Act transformed child welfare services in the United States. The expansion of the American welfare state infrastructure enlarged the sub-systems embedded within it, including the then-embryonic public child welfare system. Title V of the Social Security Act authorized public, state-level child welfare agencies in rural and special-need areas to provide services "for the protection and care of homeless, dependent, and neglected children, and children in danger of becoming delinquent."[23] As the first national law of its kind, the Social Security Act legitimized child welfare services as its own specialized field, and especially boosted both the visibility and funding for public child welfare in a field that was still mostly dominated by private agencies. By separating financial aid to children (Title IV) from child welfare services (Title V) it also reinforced social work's casework approach, which

[23] For the original SSA text, see https://www.ssa.gov/history/35act.html, accessed May 18, 2020.

focused on psychological services and largely avoided direct responsibility for poverty, as the primary approach for child welfare.[24]

Yet while the Social Security Act established a basic infrastructure and jurisdiction for child welfare, there were relatively few workers on the ground to provide services. By 1945, half of state welfare departments incorporated a child welfare division, double the 1935 number (Children's Bureau 1946), but these divisions were poorly staffed: in California in 1938, child and family welfare comprised only 6.2% of social workers, while 79.2% worked in unemployment relief and public assistance (Holzschuh 1938). In 1945, there were only 2,500 full-time public child welfare workers throughout the entire country, and almost none were in urban areas, which remained predominantly under the jurisdiction of private, largely religious, agencies. Private agencies were prohibited from directly receiving federal funds (Morgan and Campbell 2011), which likely contributed to the decline of some private agencies, in particular private agencies focused entirely on child protection (De Francis 1956, 1967). As a result, by the early 1950s, a fragmented and poorly staffed public child welfare infrastructure served about two thirds of the children receiving services, while the other third was served by private child welfare agencies, mostly in urban areas (Children's Bureau 1955). In the 1950s, private agencies were shrinking; in contrast, the number of public child welfare workers grew gradually over time, but workforce shortage remained a constant concern for welfare administrators for decades (Children's Bureau 1946; Witte 1962).

The gradually growing dominance of public, state run services had important consequences for the development of child welfare. The public/private agency division of labor influenced how new resources for child welfare were utilized and how child welfare policy developed during that foundational period from 1935-1950. The Children's Bureau remained an influential actor in shaping these policies, and, in particular, in carving out the role of public child welfare. In 1935, the Children's Bureau advisory committee, assembled soon after the passage of the SSA, pushed to direct newly available federal funds primarily toward expanding rehabilitative services, focused on therapeutic casework, as opposed to foster care and institutional care, which were already mostly financed by private and state agencies (Children's Bureau 1946). "Services" signaled an administrative logic of rehabilitative services that pervaded the broader public American welfare administration in the 1950s, emphasizing casework, which combined therapeutic conversations and referral services for individuals. This rehabilitative services approach built on casework as the signature practice of social work, but it was also a response to the politicization of welfare in the United States. A rehabilitative agenda was promoted by progressive welfare advocates and administrators, mostly outside of child welfare, who argued that poverty could not be cured by hand-outs alone, in part because they realized that strong political opposition to cash relief meant it would never reach adequate levels in the United States. Instead, casework services would rehabilitate the poor by focusing on the psychological and other needs that only a trained caseworker could provide for individuals, even as that approach largely ignored social determinants of poverty (Levin 1968; Mittelstadt 2005).[25]

Influenced by publications from the Children's Bureau, child welfare advocates adopted

[24] For another important outcome linked to the growth of public services: See also section below, "Geographic Expansion," on how the growth of public child welfare services, as opposed to private services, helped shape racial overrepresentation in child welfare.

[25] For more on the roots of social worker and welfare administrators' advocacy for social services, see (Coll 1995; Ehrenreich 1985; Leiby 1978; Mittelstadt 2005).

and linked this influential rehabilitative logic to an emphasis on a large, if not always attainable, array of children's needs, for which a growing workforce was required. By 1946, a Children's Bureau publication explained that: "It is now recognized that a program of child welfare services must include a variety of services taking into account the total needs of children. Foster care is a part but not a major function of such a program…"

"Total needs" indicated a broad range of rehabilitative services geared toward children as a target population. By the 1940s, services provided by public child welfare agencies included counseling and referrals related to mental health, foster care and adoption coordination, local casework services (i.e. therapeutic counseling), "crippled" children's and medical services, protective services for abused and neglected children (in-home counseling), economic assistance, and medical services, especially for maternal and infant health, and more (Arnold 1947: 19). Child welfare workers saw their role as counseling families dealing with crises and referring them to appropriate resources when possible. In this way, advocates linked the rehabilitative logic of child welfare administration to a long standing cultural schema—rooted in the Children's Bureau's original mandate in 1912—that public child welfare services should be comprehensive and universal, that is, they should "provide complete coverage" of all children's needs (Arnold 1947: 2).[26] Reinforcing this logic, the Children's Bureau's research department widely disseminated frequent publications on a broad range of issues affecting children, the client constituency, to child welfare agency workers, researchers, and parents.[27] As Figure 1 shows, these publications covered issues that ranged from diseases to adoption and administrative issues for workers, while focusing on child-rearing advice for parents. (See Figure 1) This broad and comprehensive approach to addressing all of children's issues was deeply linked to a specifically public child welfare vision, in which all children—not just the local or religious target population of private agencies—deserve support. However, as one of the most influential sources of data and publications, the Children's Bureau shaped the narrative of child welfare at the time and thus had an impact on private agencies as well.

As early as 1946, the emphasis on a multi-service, population-oriented system was evident in the expanding availability of services on the ground. As a Children's Bureau report noted:

> A beginning has been made in every State toward providing local services for children. In State after State, children in need of service have become "visible" as workers have been available to provide help for them. There has been increased recognition of the need for special skill in handling the problems of children… This has resulted in a feeling of responsibility on the part of local communities for the development of comprehensive public services to assure children of the opportunities and privileges contributing to good citizenship. (Children's Bureau 1946: 9)

The gradual expansion of such services enabled child welfare advocates, especially the Children's Bureau, to construct children as a population that was increasingly "visible" to social service agencies, which provided services that could shape these children into "good" citizens.[28] Establishing children as a population with specific and unique needs functioned as an

[26] The universal element could also be seen in the language of 1930 Children's Charter produced at the White House Conference on Children and Youth, which described a vision in which services are provided "for every child." (Smith 1968).

[27] See National Archives and Records Administration, RG 102, Central File 1949-52, Box 286 for multiple publication and data requests to the Children's Bureau during the 1949-1952 period.

[28] See Schneider and Ingram (1993) for more on the construction of target populations.

administrative logic of population-oriented child welfare governance, and empowered child welfare agents to assess and manage all issues associated with children. This process, which Foucauldian scholars would call biopower, or the power of the state to construct and manage populations (Foucault et al. 1991), was here extended to state-sanctioned professionals as a way of defining and expanding their jurisdiction. In practice, these rehabilitative and population-focused logics of administration were promoted by Children's Bureau consultants providing direct guidance to child welfare workers in state agencies on service provision, guidance that emphasized a broad range of services (Children's Bureau 1949, 1950b).

Child maltreatment, in this multi-issue rehabilitative framing, remained an important issue for child welfare. Contrary to existing scholarship, child welfare publications and congressional testimonies regularly noted protective services for neglected and abused children throughout the 1940s and 1950s (Anderson 1989; Arnold 1947; CWLA 1937; Gane 1940; Jeter 1960).[29] Child welfare organizations like the Child Welfare League of American (CWLA) and the Children's Division of the American Humane Association (AHA) published standards for child protection, distributed to child welfare agencies (Anderson 1989; CWLA 1937). This sense of jurisdiction over the issue of child maltreatment was not simply rhetoric. The Children's Bureau's earliest comprehensive surveys of all public child welfare services took place in 1959-1961, before mandated reporting laws were passed. These surveys found that in 1959, 49% of in-home services (in the twenty states reporting this information) were for cases related to abuse or neglect (Jeter 1960: 5). The 1961 survey found that "neglect, abuse or exploitation" of children was a primary issue in 46% of public child welfare cases, with 38% of such children in foster care (Jeter 1963: 18, 215).[30]

Indeed, child welfare did not "discover" child abuse in the 1960s, as contemporary scholars argue (Myers 2006; Nelson 1984); instead, administrators saw it as one of many issues that a rehabilitation-focused profession sought to address. During the 1949 congressional hearings on revisions to the Social Security Act, Children's Bureau chief Katharine Lenroot argued for increased services for handicapped children, as well as those suffering from "neglect, abuse, desertion, delinquency and deprivation" of those "elements required for the full development of the child's capacities to get on in the world and live happily with other people."[31] In this framing, child welfare was a system that targeted children as a population with a wide variety of needs, including maltreatment. These needs, advocates argued, could be met with a well-staffed nationwide child welfare infrastructure, whose focus, at least in theory, was to

[29] See testimony of Katherine Lenroot in Social Security Act Amendments of 1949. Hearings before the Committee on Ways and Means. H.R. 2892. March 3, 1949, p. 417. Lenroot argues that child welfare service providers address "child neglect, abuse, delinquency," as well as handicapped children's needs and poverty, and that these services should receive greater support. A Children's Bureau report discusses protective services for abused and neglected children as the "rightful function of the public agency (Arnold 1947). Gane views protective services as oriented toward either neglect in the home or exploitative child labor (Gane 1940), but cites the CWLA 1937 report, which provides significant and broad detail on the types of abuse and neglect that justify interventions by protective organizations (CWLA 1937). Anderson (1989) notes in footnote 2 that the idea that medical professionals "discovered" child abuse is based on a semantic misunderstanding. He establishes that child welfare agencies were focused on child abuse and neglect but used different terms—such as "cruelty"—which later researchers did not recognize as referring to essentially the same issues.

[30] Interestingly, it was a primary problem in only 21% of private child welfare agency cases—though private agencies served only 36% of cases—because of the focus of these primarily Catholic agencies on "illegitimacy," which was a primary problem in 35% of their cases (Jeter 1963: 18).

[31] For Lenroot testimonies, see Social Security Act Amendments of 1949. Hearings before the Committee on Ways and Means. H.R. 2892. March 3, 1949, p. 417-419.

provide a wide range of services in family home settings, seeking to "supplement the efforts of parents" to care for their children (SSB 1950).[32] This also meant that a rehabilitative approach was essentially a family-focused one, as an emphasis on children's comprehensive needs often meant a focus on their family needs, as evidenced by the many publications on child-caring practices targeted at parents.[33] A family-based approach to rehabilitative service was partly inspired by a maternalist vision of welfare reform, a deeply rooted cultural schema that scholars have noted obscured classist and racist ideologies idealizing stay-at-home motherhood, and ignored the needs of working and minority women (Berry 1993; Ladd-Taylor 1994; Michel 2013; Miller 1998).

In practice, an individualized, therapeutic, and family-focused approach translated into relatively little attention paid to racial inequality or poverty. In one example of how cultural schemas linked to pre-existing policies shape norms, building on a long history of inadequate attention to racial and class inequities, child welfare advocates pointed at ADC as the program responsible for financial aid, which, they argued, freed them to focus on "behavior and social adjustment" focused services, not poverty.[34] The ADC was clearly inadequate to deal with poverty issues, and did not serve a large population of working poor families who in fact constituted a significant portion of child welfare clients;[35] the ADC also greatly discriminated against African American and other minority mothers at the time. Yet the lack of resources for child welfare workers to address poverty or racial inequality translated into relative silence on the issue in public child welfare discourses, even if child welfare workers often dealt with families in financial crises.

Indeed, while poverty was frequently discussed by child welfare practitioners and researchers as one issue that "multi-problem" families faced (Boehm 1964; Rawley 1962), racial inequality and poverty were rarely accounted for in national surveys or professional publications. The "U.S. Children's Bureau Statistical Series" (1950-1967) on child welfare services did not include children receiving services solely because they were beneficiaries of ADC; this had the somewhat ironic outcome of excluding a significant sub-group of children receiving welfare services from national surveys because those services did not fit with the psycho-therapeutic, individually oriented logic of rehabilitative services. To be clear, this does not mean that child

---

[32] This Social Security Bulletin noted: "The primary aim of child welfare work is to make it possible for children to receive the care they need in their own homes…" (SSB 1950). This aspirational framing, however, did not match reality: a majority of children that child welfare workers served in the 1950s were in foster or institutional care, and the number of children in foster care only rose in the following years. See the "U.S. Children's Bureau Statistical Series" (henceforth CBSS) 27, 1952: 4; CBSS 32, 1954 (no page numbers); CBSS 45, 1957: 3-4.

[33] In practice, "family services" and "children's services" were sometimes conflated, and the 1940s saw multiple mergers of family and children's agencies (Levin 1968). These shifts were linked to the process in which child welfare professionalized and expanded as an independent professional field, while family services, by contrast, found less of a niche in social services. The establishment of the ADC program, which provided financial aid for families, was also linked to a gradual decline in family service agency cases by the 1950s (Shyne 1953); between a decrease in families who needed financial aid from such agencies, and the growth of child welfare resources to address children's issues, family agencies appeared to fill less of a social need, although they did continue to provide services until the 1970s, at which point their numbers dropped dramatically. See section below entitled "Managerial Efficiency" for more on how family services were eventually integrated into child welfare services.

[34] National Archives and Record Administration, RG 287, Box 572, FS 3.202: P 95 - FS 3.202: Y 8/2. 1959. "Report of Advisory Council on Child Welfare Services, 1959," p. 25.

[35] The Children's Bureau did not collect data on the proportion of child welfare clients that were children in low-income families for the 1950s and 1960s. However, *Child Welfare* journal articles discuss poverty as at least one issue in families that practitioners regularly engaged, particularly with cases of neglect (Boehm 1964; Rawley 1962).

welfare workers did not counsel families with financial issues. Poor families with working parents were not eligible for ADC and some still received local services, and articles in *Child Welfare*, the long-running journal of the flagship child welfare agency association, the Child Welfare League of America, indicate that child welfare practitioners often counseled families in financial crises (Boehm 1964; Rawley 1962). However, child welfare professionals still did not see that as their primary responsibility, even if it often arose in their actual work. As part of a larger analysis of the *Child Welfare* journal, I found only six articles from 1950-1958 (out of a total of 396) devoted primarily to the issue of poverty, and two to issues related to racial minorities,[36] in contrast to 162 devoted to administrative issues and social work practices, indicating that the primary concerns in which child welfare practitioners engaged in this period were administrative, not poverty or racism. These relatively small proportions remained the norm throughout the 1960s. Poverty and race were discussed as part of larger discussions, particularly during the "war on poverty" era in the early 1960s, which saw a spike in poverty-related discussions. But with limited access to poverty relief programs and a strong, welfare state-wide push for casework services, child welfare workers did not have the resources to deal effectively with poverty issues, and thus did not view poverty as their primary responsibility; instead, inspired by a rehabilitative logic of welfare administration, child welfare workers focused on a wide range of social services.

II. 1950-1967: Expansion of Infrastructural Capacity and Jurisdiction

Rehabilitative and population-focused logics of child welfare administration, promoted by the Children's Bureau in particular, drove advocacy efforts for child welfare expansion. In 1949, an estimated 3,386 child welfare workers worked in public agencies in the entire country (Children's Bureau 1950a: 11). State and federal welfare administrators, along with representatives from the Children's Bureau and other non-profit child and family advocacy organizations, appeared in multiple congressional hearings in 1949 and the 1950s, advocating for expanded federal support of child welfare, as part of a larger expansion of a service-oriented American welfare state (Coll 1995; Mittelstadt 2005). Advocacy took place on the state and local level as well, and in response, funding for services grew steadily and dramatically, with total federal, state, and local funding rising from 23.2 million in 1952 to 155 million in 1967 (see Figure 2).[37] The expansion, starting in the early 1950s, pre-dated the Johnson administration's War on Poverty and was pushed by an overriding logic of rehabilitative services. Even as institutionalization of children declined, there was a large increase in children in public foster care throughout the 1950s (Winston 1960).

A decade of infrastructural growth was reinforced by the 1962 Public Welfare Amendments (PWA), which established the legitimacy of "services" by guaranteeing federal

[36] One of these articles discussed the challenges of adoption placement for African American infants, specifically because of their race and physical appearance (Johnson 1950). The second was about a child care center set up for children of Hispanic migrant workers, for whom special accommodations needed to be made due to their economic challenges and cultural differences (Anon 1958).

[37] This data is from the U.S. CBSS 1952-1967, report numbers 18, 23, 36, 46, 51, 55, 60, 64, 66, 72, 75, 82, 84, 88, 98, published by the Children's Bureau. When adjusted for inflation, the 1952 total was approximately 29 million in 1967 dollars, still a dramatic rise. Note that on all levels of governance, the funding grew on relatively similar scales, by about 6-7 times the original sum. For more on the history of federal funding for child welfare, see Green Book 2011: https://greenbook-waysandmeans.house.gov/sites/greenbook.waysandmeans.house.gov/files/2011/documents/Child%20Welfare_Legislative%20History.pdf, accessed September 7, 2020.

coverage of 75% of state welfare costs if services were incorporated, and massively expanding open-ended funding for social services (Cohen and Ball 1962). A rehabilitative logic pervaded advocacy for child welfare in the PWA hearings, albeit distinct from poverty relief. Testimony for the 1962 amendments included the full 1959 Advisory Council on Child Welfare Report, which urged increased services, noting that:

> Since basic economic problems which used to bring families to child welfare agencies are now handled through Old-Age and Survivors Insurance and public assistance programs, specialized child welfare programs deal more and more with behavior and social adjustment problems. As a consequence the demand for psychological and psychiatric counseling and treatment has increased.[38]

Despite some pushback from child welfare experts that "public child welfare services have been too fat and too enriched as compared with public assistance" (Sampson 1962), the Council's statement indicates that child welfare remained firmly focused on services, even when involved in ADC cases (Mitchiner 1966). An administrative logic of multi-service rehabilitation was linked to a deeply rooted cultural schema that deprioritized poverty, partially as the result of other available financial aid-focused programs. The Advisory Council, appointed by congress in the 1958 Social Security amendments and populated by a who's who of child welfare leaders, argued that more services required more staffing, noting that agencies have not "been able to keep up with the mounting social problems that bear upon the welfare of children—divorce and separation, juvenile delinquency, illegitimacy, employment of mothers. The shortage of personnel virtually represents a national emergency not only for child welfare but for social welfare as a whole."[39]

The focus on services was reflected in the child welfare's infrastructural expansion. As Figures 3 and 4 shows, federal and state funding increases translated into a consistent yearly rise in public child staffing and caseload, from 8,740 workers involved in 270,000 children in 1950 to 25,991 involved in 607,900 children in 1967, a much higher rise than the growth in the number of children over the same period of time.[40] This reach to cover a larger portion of American children was encouraged by a clause in the PWA, which specified that states must make child welfare services available throughout the state by 1975 in order to qualify for federal funds (Cohen and Ball 1962). Indeed, the number of both public and private agencies affiliated with the Child Welfare League of America, which published agency member directories every few years, grew from 287 in 1950 to 369 in 1961 to 596 in 1971. By using ARCGIS to transform historical address data into maps, we can see both the growing number of agencies, their expansion into areas, such as the Midwest, that previously had no agencies, and their growing

---

[38] National Archives and Record Administration, RG 287, Box 572, FS 3.202: P 95 - FS 3.202: Y 8/2. 1959. "Report of Advisory Council on Child Welfare Services, 1959," p. 24-25.

[39] National Archives and Record Administration, RG 287, Box 572, FS 3.202: P 95 - FS 3.202: Y 8/2. 1959. "Report of Advisory Council on Child Welfare Services, 1959," p. 32.

[40] The number of caseworkers tripled, while the child population grew from 47.3 to 69.9 million. The case rate (number of children served divided by child population) grew from .0057 to .0087, or a 35% growth. For U.S. census data on child population see: https://www.childstats.gov/americaschildren/tables/pop1.asp, accessed September 7, 2020. The data on the number of child welfare workers employed is available in the CBSS, published by the Children's Bureau between 1946-1967, report numbers 7, 13, 16, 20, 30, 41, 51, 55, 60, 66, 72, 75, 82, 84, 88, 92; see also Arnold 1947:3, and testimony of Katherine Lenroot in a February 1949 hearing before the Ways and Means Comm., House of Reps., 81st Congress, First Session on HR 2892, p. 422-423. Data on the number of children served employed is available in the CBSS, published by the Children's Bureau between 1957-1967, report numbers 45, 55, 60, 64, 66, 72, 75, 82, 84, 88, 92.

concentration in urban regions in the northeast with higher numbers of African American children. The disproportionate impact on African American families is elaborated in the next section, although southern regions with larger African American populations remained severely underserved (See Figure 5). More agencies in more locations meant more families could receive (both wanted and unwanted) services from a rapidly expanding child welfare system. Specifically, infrastructural expansion led to three important forms of jurisdictional expansion, each elaborated below: spatial jurisdiction, which led to increased authority over families of color; increased jurisdiction over poor families as a population; and new jurisdiction over a substantive issue—cases of maltreatment. The Children's Bureau played an important role in each of these three expansion processes.

Geographic Expansion: The Racialized Implications of Increased Urban Jurisdiction

Building on growing resources, public child welfare infrastructure expanded geographically during the 1950s. In 1958, federal administrators wrested control over urban child welfare from Catholic and other private agencies, who had been the designated authorities in urban areas since the 1935 Social Security Act specified that public services should focus on rural and high-needs areas.[41] For years, Children's Bureau representatives, ideologically driven by a universalist population logic that demanded equal services to all, had argued that federal funding for public services should be allowed for urban areas as well (Rosenthal 2000: 286). A letter from the Children's Bureau chief Martha Elliot in 1954 to the Social Security Commissioner explained their reasoning: "The state and local public welfare agencies cannot be expected to give up their overall legal responsibility to assure equal opportunity for homeless, neglected, dependent, or delinquent children to receive protective welfare services when they are in need."[42] The Children's Bureau's case was supported by a powerful consensus among representatives of state, local, and private welfare and children's organizations, who testified to the importance of lifting restrictions on federal funding for urban areas in the 1956 and 1958 congressional hearings.[43] In addition, federal social welfare leaders argued that a growing population of urban children were severely underserved by existing private urban services.[44] Although race was not mentioned as a factor in this urbanization trend, later research revealed

[41] Note that religious agencies had been deeply involved in running most American child welfare institutions, particularly on the east coast of the USA, for centuries before the post-SSA massive expansion of public child welfare. For details on the debate between the Children's Bureau and Catholic agencies, see statement of Monsignor John O'Grady to the Ways and Means Comm., April 16, 1956 and Children's Bureau response in National Archives and Record Administration, RG 102: Central Files 1953-1957, Box 560, Folder 0-2-3-1. For more on this topic, see Rosenthal 2000.

[42] National Archives and Record Administration, RG 102, Central File 1953-1957, Box 560, Folder 0-2-3-1. Statement dated March 17, 1954 by Martha Elliot, Children's Bureau Chief, to John W. Tramberg, Commissioner of Social Security.

[43] These advocates included representatives from the Child Welfare League of America, American Parents' Committee, the American Public Welfare Association, and the National Association of Social Workers, as well as a variety of state and federal welfare administrators (see Public Assistance Titles of the Social Security Act, Hearings before the Ways and Means Comm., House of Representatives, 84th Congress, Second Session on H.R. 9120 and H.R. 9091, April 12-20, 1956; Social Security Legislation, Hearings before the Ways and Means Comm., House of Representatives, 85th Congress, Second Session on all titles of the Social Security Act, June 16-30, 1958).

[44] See testimony by Charles I. Schottland, Commissioner of Social Security, DHEW, p. 8, and testimony by Martha M. Elliott, Children's Bureau Chief, p. 26-27, in Public Assistance Titles of the Social Security Act, Hearings before the Ways and Means Comm., House of Representatives, 84th Congress, Second Session on H.R. 9120 and H.R. 9091, April 12-20, 1956.

that African American children were especially ignored by private religious agencies (Bernstein 2002), and constituted a significant portion of those underserved children. In 1958, the long years of advocacy paid off. Religious agencies' vigorous efforts to hold on to exclusive control failed, and public child welfare agencies rapidly expanded jurisdiction over urban areas (Families et al. 2013: 110).

The urbanization of public child welfare changed the color of child welfare. The percentage of children receiving public child welfare services identified as non-white (primarily African American) climbed from 15% in 1945—already an overrepresentation relative to their proportion of the population—to an even larger overrepresentation of 25% in 1959 (Jeter 1960: 50). Beyond general services, by 1959, as part of a larger expansion of foster care placement specifically, African American children constituted 30% of public and 18% of private foster care placements, significantly more than the 10.5% that they constituted of the general population (Jeter 1960).[45] In addition to the urbanization and infrastructural expansion of public child welfare, the migration of millions of African American families from the rural south to urban areas in the north and Midwest during the early and mid-twentieth century was another structural factor that likely led to more African American children served by child welfare in urban areas. These changes all took place in the 1950s, undermining an existing scholarly narrative that argues that child welfare actors largely ignored African American families until the 1960s, and then disproportionately removed African American children from their families in response to changes in ADC regulations that increased funding for foster care for ADC recipients, and in response to the 1960 Flemming rule, a federal regulation pushed by some legal advocates that (inadvertently) incentivized foster care placements (Billingsley 1972; Lawrence-Webb 1997; Raz 2020; cf. Simmons 2020).[46]

This chapter's findings indicate a fundamental misunderstanding by these sources of the key issue that affected racial representation in child welfare services: public versus private agencies. Private, usually religious, agencies consistently underserved minority families, and because they dominated child welfare services before the SSA, this meant that minority children were underserved in much of child welfare; indeed, private agencies continued to underserve minority children in some areas until late in the twentieth century (Bernstein 2002; Simmons 2020). When public child welfare agencies expanded their infrastructure and began to dominate child welfare services, and especially as they moved into urban areas with far more African

[45] For population data: childstats.gov: https://www.childstats.gov/americaschildren/tables/pop1.asp, accessed September 7, 2020.

[46] This argument, made by Lawrence-Webb (1997) and discussed or cited by others (Berrick and Heimpel 2020; Dettlaff and Boyd 2020; Jimenez 2006) claims that the Flemming rule, which was meant to counteract racially biased state removals of African American families from welfare rolls, in fact encouraged foster care placement of African American children, an argument supported by research on how HEW's directive generally increased foster care (Frame 1999: 729). Lawrence-Webb's primary evidence is that a disproportionate 25% of foster care children were African American in 1961, the year after the Flemming rule was passed, as cited in the Children's Bureau's "Jeter" report (Jeter 1962). However, an earlier survey in the Jeter report series showed that in 1959, 30% of placements were "nonwhite" children—identified by the report as "nearly synonymous" with African American children (Jeter 1960: 9, 21), which meant that the proportion of African American children in foster care actually decreased after the Flemming rule, and that it was already disproportionate beforehand. This data supports the paper's claim that infrastructural expansion was an important factor in the racialization of child welfare, although other factors may have contributed to the continuing rise, including the Flemming rule. Indeed, the data in this chapter does not, in fact, undermine the larger point, which is that the percentage of African American children in foster care rose throughout the twentieth century to an astounding 60% of all foster care children by 1990 and 64% by 1999 (Freundlich and Barbell 2001: 5).

American children in the late 1950s, the number of children of color rapidly climbed. That is, what changed in the 1940s-1960s was not about the discovery of child abuse or federal regulations, though that likely compounded matters. Instead, it was the infrastructural expansion of public child welfare, which served a disproportionate number of African American families as far back as 1945. As a result, African American and other minority children went from suffering from a lack of comprehensive child welfare services to overrepresentation in an increasingly punitive child maltreatment-focused system.[47]

This reconstructed historical survey data demonstrates a key point of this chapter: this is a story about infrastructural expansion interacting with shifts in jurisdictional boundaries. The expanding infrastructural capacity of public child welfare, both in resources and in geographic reach—especially over urban populations—preceded both federal regulatory changes and state-level mandated reporting laws in the 1960s and contributed to a form of structural racialization of child welfare. By structural racialization, I mean that these findings do not indicate (though they also do not disprove) that individual social workers disproportionately singled out families of color for interventions. But they do support the argument that simply by expanding child welfare's authority so that it was now structured to provide increased services in urban areas, child welfare agencies were more likely to intervene in families of color.

Population Expansion: Increased Jurisdiction over Poor Families

The 1962 PWA amendments formally integrated financial aid and social services to families, thereby extending child welfare's jurisdiction to a new population of poor families across the country. As part of this effort to rehabilitate the poor, families receiving AFDC (Aid to Families with Dependent Children, the new name in 1962 for the ADC) were required to receive casework services, and every child recipient of AFDC was supposed to receive a full "social study," coordinated with child welfare and family service agencies (Cohen and Ball 1962; Families et al. 2013). For decades, a focus on psychological services and a deferral of financial problems to ADC administrators meant that child welfare largely evaded direct responsibility for issues of poverty. This did not so much indicate that they did not work with poor families, as much as they evaded acknowledging it. A 1959 report by the Advisory Council on Child Welfare (incorporated into the hearings for the 1962 PWA amendments) noted that poverty was not as central a practice as psychological counseling for child welfare, citing a statistic that only 9% of children receiving services were in families on public assistance rolls.[48] This claim ignored the many working poor families who were ineligible for the newly renamed AFDC and families of color who were denied benefits, yet poor working-class families were still common recipients of child welfare neglect investigations and interventions. The expansion of child welfare's

[47] As noted in the introduction to this dissertation, these findings do not necessarily mean that other factors did not also play a role in the overrepresentation of African American children in child welfare. The data in this dissertation does not show that the federal and state actors involved in this infrastructural expansion accounted for race as a motivation for it. However, tensions between public and private agencies, the lack of attention to minority families by private agencies, as well as significant income inequalities and racially discriminatory implementation of New Deal policies that contributed to the poverty of minority families, may have all also played a role (Simmons 2020). What the data in this chapter does establish definitively is that the story of racially unequal outcomes in child welfare well predated broader welfare changes noted in published scholarship, including the overrepresentation of minorities in public assistance programs in the 1960s, and that infrastructural expansion played a major role in enabling child welfare's disproportionate focus on minority children.

[48] National Archives and Record Administration, RG 287, Box 572, FS 3.202: P 95 - FS 3.202: Y 8/2. "Report of Advisory Council on Child Welfare Services, 1959."

jurisdiction to an explicit responsibility for poverty, through specific inclusion in services to AFDC families, was supported by child welfare workers who felt that a truly comprehensive approach to child welfare required directly engaging with poverty issues (Sampson 1962).

In practice, however, implementation of newly mandated child welfare involvement in poor families was highly inconsistent, and many areas of the United States still had almost no child welfare services despite a population-oriented commitment of services "for every child" (Smith 1968, citing White House Conference - Children Charter, 1930). Yet even if largely aspirational in practice, this shift lay the groundwork for increasing child welfare interventions in poor families in later years, a trend that has continued to this day. By 1977, due to the expansion of eligibility for AFDC to families of color and single parents who were previously denied their benefits, 38% of children receiving public child welfare services were in families receiving AFDC, as opposed to just 7% in 1956 (Abramovitz 1996; Jeter 1960; Shyne and Schroeder 1978). Increasing services eventually meant a higher likelihood of mandated reports of neglect, potentially a proxy for conditions of poverty, and more harsh surveillance and separations of children from their poor families (Drake, Lee, and Jonson-Reid 2009; Pelton 2015a).

Substantive Issue Expansion: Child Maltreatment

The passage of the Public Welfare Amendments (PWA) in 1962 redefined child welfare services:

> "…[C]hild Welfare means public social services which supplement, or substitute for parental care and supervision for the purpose of (1) remedying or assisting in the solution of problems which may result in the neglect, abuse, exploitation, or delinquency of children, (2) protecting and caring for homeless, dependent, or neglected children, (3) protecting and promoting the welfare of working mothers; and (4) otherwise protecting and promoting the welfare of children, including the strengthening of their own homes where possible or, where needed, the provision of adequate care of children away from their homes in foster family homes or day-care or other child-care facilities" (PWA 1962).

This definition of child welfare is far more specific in its definition of child welfare authority than the original 1935 SSA text, and it is the first time the word "abuse" appears in the text of the Social Security Act revisions. This specificity had multiple implications, but perhaps most importantly, it clearly indicates expansion of "*parens patriae*"—parental authority of the state, as embodied in child welfare workers (Abrams and Ramsey 2003). The textual extension of child welfare authority built on the convergence of ongoing infrastructural expansion and professional advocacy for increased protective services. Maltreated children had long been a target population of child welfare (Anderson 1989; Arnold 1947: 5; Jeter 1960, 1963), but the AHA's damning reports decried the over-use of foster care placements, arguing that more dedicated in-home protective services were needed to address this issue (De Francis 1956). The reports and growing, mostly medical, research on the parental abuse of children, led to intensive media coverage of the issue by the early 1960s, perhaps most famously a widely-cited article entitled "The Battered-Child Syndrome" in 1962 (Kempe et al. 1962; Lindsey 2004). Increased awareness contributed to the construction and rapid diffusion of model state statutes for mandated reporting of child maltreatment (Raz 2020).

While this history is well-covered in child welfare scholarship, these studies argue for advocacy by child welfare advocates and medical professionals as the primary factor in

increasing awareness of child maltreatment, thus fueling the rise of the modern child welfare system (Lindsey 2004; Nelson 1984; Raz 2017). As this chapter establishes, the current scholarship overlooks the importance of the infrastructural expansion of child welfare. The state reporting laws demonstrate how the narrowing focus to maltreatment was a key juncture in child welfare history, one that illustrates the impact of infrastructural capacity on welfare jurisdiction in two ways. First, the original model statute for mandated reporting of child maltreatment promulgated by the Children's Bureau in 1963 required reporting to a "police authority," because of the assumption that law enforcement was available in every area. Just three years later, in 1966, the Children's Bureau, the most influential institution in child welfare at the time, shifted its recommended primary recipient for reports to child welfare authorities. As a contemporaneous legal scholar noted, "in light of the rapid expansion of protective services and the institution of comprehensive child welfare programs," the Children's Bureau recommended that when possible, child welfare agencies respond to maltreatment reports (Paulsen 1966: 713).[49] As the most influential of several available model statutes, the Children's Bureau shift was a reflection of a growing belief not just in the superior efficacy of child welfare in addressing family issues, as opposed to the carceral model, but in child welfare's newly expanded infrastructural capacity to do so (Paulsen 1967b).

Second, state laws passed from 1962-1967—the period in which all states passed a mandated reporting statute (Myers 2006; Nelson 1984)—and revised in the following decades indicate a clear shift toward child welfare or social services as the primary authority. Figure 6 and Table 1 use 50-state surveys of mandated reporting laws, choosing one survey a decade from 1966-1987, to indicate how an increasing number of state laws mandated social services as a primary authority (See Figure 6). From 1966-1987, the number of states that required reports solely to social services doubled from eight—of which only four mandated child welfare as the primary authority (Paulsen 1967: 18)—to sixteen, while those that required reports solely to law enforcement declined from nineteen to four; the number of states requiring both (although law enforcement usually deferred to social services due to policies that mandated child welfare interventions in such cases) rose from sixteen to thirty. This shift from police to child welfare as the primary intervention authority was in large part due to the growing momentum of funding that enabled surveillance of children in their homes, and expansion of child welfare's jurisdiction to conduct that surveillance. Institutionalization, in deep decline in the early 1960s, was gradually replaced with federally funded protective services and foster care in the 1950-1970 period (Newgent 1963; Shyne and Schroeder 1978).[50] Child welfare's growing infrastructural capacity, fueled by rapid funding, staffing, and agency growth, all with origins that predated mandated reporting laws, enabled an increase in agencies' jurisdiction to intervene in maltreatment cases. Well into the 1970s, maltreatment remained a growing issue, but still

[49] An alternative model statute put out by the American Humane Association in 1963 advised reporting to social services providing child protection, while others recommended a mix of welfare, health, and police authorities (McCoid 1965: 17; Paulsen 1967: 16-18).

[50] Decreasing institutionalization began in 1935, with children who previously had been too poor to live at home, now able to do so due to ADC payments; foster care placements under public child welfare supervision rose significantly during this period as well (Winston 1960). Institutionalization further declined in the 1960s, and deinstitutionalization was a top priority for the Office of Child Development in 1970 (see National Archives and Record Administration, RG 235, Box 5. Folder: CB OCD October-November 1969. Handwritten list entitled "Potential Special Priorities FY 1977").

integrated into a rehabilitation and population driven logic of child welfare administration that focused on multiple services to children. This was all about to change.

III: 1967-1980: Jurisdictional Contraction

Even as child welfare was expanding its infrastructural capacity to serve its target population of children, a backlash to rehabilitative services was brewing in American welfare administration by the early 1960s. The backlash was driven by a logic of managerial efficiency in welfare governance. Managerial efficiency meant administrative minimalism, clearly defined and measurable services, and a focus on narrowly defined problems, none of which were compatible with a rehabilitative focus on multi-issue populations. This shift was amplified by growing anti-casework sentiments, which began with opponents to the Johnson expansion of welfare programs and intensified during the conservative and anti-social work Nixon administration. The findings in the first segment below first explain the rise of a logic of managerial efficiency in welfare governance, resulting in debilitating cuts to child welfare programs. In the second segment, the findings show how these trends also hollowed out the Children's Bureau, weakening the central source of the rehabilitative logic that had guided state and local agencies. Together, anti-casework and managerial efficiency trends converged with child protection advocacy to reorient an expanded child welfare infrastructure, contracting its jurisdiction to the issue of maltreatment.

Managerial Efficiency: The Case against Casework

Beginning in the Kennedy and Johnson administrations, and culminating in Nixon's presidency, federal administrators, heavily influenced by economists, pushed to restructure social services in ways that conformed to an emerging governing logic of managerial efficiency. In practice, this meant that administrators shifted programs away from services organized to meet the wide-ranging needs of a particular constituency and toward clearly defined services that aimed at resolving specific problems (Nelson 1984: 48; Phillips 2017). The Kennedy administration first introduced a business management approach to governance, and Johnson's administration attempted to institute it in all federal agencies in 1965 (Leiby 1978). In the mid-1960s, economists gained increased control of the OEO (Office of Economic Opportunity), which provided evaluations of federal program efficacy, in response to pro-welfare administrations' quest for measurable data on welfare outcomes. Economic evaluations of welfare programs focused on concrete outcomes, and discounted the "soft" services, primarily social casework, that then dominated federal welfare programs (Leiby 1978; Randall 1979; Steensland 2008).[51]

By the late 1960s, federal agencies increasingly employed administrators driven by an interest in efficient program management, and a distinct disinterest in traditional social work values and practices, such as casework and population-focused rehabilitation. A most notable example was Mary Switzer's 1967 appointment to lead the Social and Rehabilitation Service (SRS), the agency in charge of social services, even as she announced that she was "not a

[51] This struggle over administrative logics in social welfare was linked to a debate between generalists and specialists in that era. The "specialists" were administrators with traditional backgrounds in welfare and social work who tended to protect the particular programs of their expertise, and "generalists" were government administrators who focused on general program management and were more committed to managerial efficiency (Leiby 1978). The business management approach favored by Kennedy and later administrations heavily favored the generalists, who entered federal agencies in increasing numbers by the late 1960s and promoted a logic of managerial efficiency.

traditional welfare person," and not a "professional" (quoted in Mittelstadt 2005: 164). Switzer, however, was still supportive of at least a rehabilitative framework, if not of professional social workers. Even that fell by the wayside by the early 1970s, during the Nixon administration. Nixon sought to undermine long-time welfare administrators, especially the politically liberal proponents of Johnson's War on Poverty ideals, in favor of programs that cut out social workers and administrators altogether and focused on direct financial support of the poor. Nixon's hand-picked department leaders installed actively anti-casework administrators and restructured the Department of Health, Education, and Welfare (HEW) to undermine a rehabilitative casework-focused approach in favor of (minimal) welfare support (Randall 1979).[52]

Opposition to casework as a solution for social problems appeared affirmed by welfare trends. By the mid-1960s, anti-welfare advocates argued that ballooning welfare rolls and an exploding federal budget—which had skyrocketed from 194.3 million dollars in 1963 to 1.7 billion dollars by 1972 (Derthick 1975: 8)—was the fault of a rehabilitative casework approach that did not work. As the APWA put it in a 1965 statement, "Congress is asking not uUnanticipated but embarrassing questions" about the rise in rolls despite the increased funding for social services (American Public Welfare Association 1969: 272). While this claim simplified a complicated multi-factor process of welfare growth, it resonated with the managerial administrators of federal welfare agencies and with legislators.[53] As Gordon Brown, the director of a 1968 study on the impact of intensive casework on recipients, stated: "You can't casework people out of poverty" (cited in Steiner 1971: 25).

What did all this mean for child welfare? Administrative and political contempt for rehabilitative casework, the "soft" counseling-based services that constituted much of family and child welfare workers' expertise, had programmatic consequences. Beginning in 1967, federal administrators began separating the administration of social services and financial aid, spurred by efforts to more efficiently organize welfare administration and the conviction that the 1962 integration had largely failed.[54] The administrative reorganization encouraged state welfare departments to merge all "family services," generally defined as counseling and referral services to families receiving AFDC, with child welfare services, as part of an effort to separate them both from their short-lived integration with financial aid services (Shyne and Schroeder 1978; Steiner 1971). This meant that child welfare workers served largely the same population of children as they had since the merger in 1962, with AFDC families still eligible for now

[52] While many of Nixon's initiatives ultimately failed, they still reshaped public sentiment to oppose federal programs, which some scholars argue contributed to the birth of neoconservatism in the late 1970s, and a broader public and political backlash against federal administrators and federally funded services (Phillips 2017; Robins 1980).

[53] Blaming the rise of welfare beneficiaries on the failure of rehabilitative casework ignored other factors, including the welfare rights movement and United States Supreme Court rulings in the 1960s that prohibited discrimination in welfare, both of which led to higher enrollment rates (Abramovitz 1996; Tani 2016).

[54] On August 15, 1967, HEW secretary John Gardner announced that federal social services administration would be separated from financial aid, arguing that there is "growing consensus that these quite different functions should be performed by different people" (Steiner 1971). The emphasis on "functions" echoed a general trend toward a more functionalist, administratively efficient welfare governance, in which each governing unit was supposed to address a similar set of problem, such that all social services would be grouped together, while finances were handled separately. See, for example, notes on a 1969 survey of the Children's Bureau staff, for the purpose of reorganization planning: "The identification of Social Services as a functional unit is in accordance with the trend to now define Social Services as distinct from assistance payments, health, and education" (National Archives and Record Administration, RG 235, Office File of Director Jule Sugarman, 1967-1969, Box 2, PI 181---Entry 34. "Children's Bureau Study, March 1969.")

integrated child and family service agencies, but workers no longer had administrative access to the financial aid that was previously integrated into these services. The number of children receiving child welfare services ballooned, reaching 1.8 million in 1977, with 38% in families receiving AFDC (Shyne and Schroeder 1978).[55]

Yet the effect of the merger went beyond the lack of financial aid; the merger, as part of a larger contraction of American welfare, debilitated much of the programming that had defined child welfare and family services. A subset of social workers had long supported the merger of child and family welfare services, in order to resolve the inefficiencies that resulted from overlapping functions, and because they hoped integration would improve both programs (Bell and Wickenden 1961: 117; Levin 1968). But that is not what happened. Instead, counseling-focused family services and casework-based child welfare services almost entirely disappeared into reorganized social service agencies offering "hard services" that rarely focused on family issues (Frame 1999). By 1969, Joe Reid (CWLA leader) noted: "In many states, many of the child welfare programs have partially disappeared" as a result of the merger.[56] As Shyne and Schroder wrote in their landmark report on child welfare services in the 1970s: "ideally implementation of this seeming logical step [of merging child and family services] could have meant upgrading services for AFDC families to the level of service for child welfare service recipients. In fact, the opposite is believed to have occurred" (Shyne and Schroeder 1978: 9). The specialized services, small caseloads, and professionally trained staff that were typical of old child welfare units, along with most family-focused services,[57] were lost in these large merged agencies. The expanded child welfare agencies, staffing, funding, and caseloads remained, but now increasingly focused on a growing number of maltreatment reports.

A logic of efficient welfare governance also profoundly impacted funding. Federal legislators and welfare administrators were now more likely to fund clearly defined "hard services" with measurable outcomes, like foster care or financial aid (Miles 1974; Coll 1995: 245-6; Leiby 1978: 236). The 1974 Title XX (Social Service Amendments, P.L. 93-647) mandated severe caps on social service funding and enabled funding only for services that were clearly specified (DHEW 1975; Gilbert 1977). The result was insufficient funding for family preservation services that would enable parents to keep their children while addressing problems in their homes. Foster care, however, remained an open-ended entitlement, as it had been since 1961, and as it remained through federal child welfare legislation in 1974 (the Child Abuse Prevention and Treatment Act) and 1980 (the Adoption Assistance and Child Welfare Act).

---

[55] See more discussion on this expansion of cases in Chapter 4.

[56] National Archives and Record Administration, RG 235, Box 5, October-November 1969. "Transcript of Proceedings, DHEW, Meeting of Robert Finch with the American Parents Committee Inc.," p. 31.

[57] This merger was the final act in the slow death of family service agencies, a decline that began decades earlier, after the ADC (later renamed the AFDC, Aid to Families with Dependent Children, in 1962) made financial aid largely irrelevant for family service agencies (Shyne 1953). The sense of imminent decline by the early 1970s could be seen in contemporaneous publications catering to family service agencies. *Highlights*, the signature publication of the Family Services Association of America (FSAA) ended in 1971, soon after this merger began. In one of the last issues, an article discussed what would happen if family services disappeared, apparently a relevant question by that time. The article cited an agency director who responded to this question by describing the general decline of a holistic approach to resolving children's problems through family-focused services. This decline, the director predicted, would unfold in a variety of ways, including the following: "The largest and most rapidly growing source of homemaker service would become non-existent" (FSAA April-May 1971). See also https://socialwelfare.library.vcu.edu/organizations/family-service-association-of-america-part-i/ for a brief history of the FSAA. Note that in 1993, the FSAA merged with another organization to form the Alliance for Children and Families.

Adoption also continued to receive strong support, relative to the much smaller sums allocated for family preservation services (Hutchinson 2002).[58] The funneling of organizational resources and infrastructural capacity toward separation of families effectively narrowed the framework of child protectionism to one that viewed children as a unit distinct from their parents, instead of an integrated family unit. This was in direct opposition to the goals of the original advocates of expanding child welfare infrastructure for more services, as well as those who had promoted increasing child protection services, both of whom had sought to ensure more in-home services (De Francis 1956; CWLA 1940; SSA 1950). The long-term impact of their advocacy, when merged with a shift in welfare administrative logics from rehabilitation to efficiency, led to the opposite effect. While many children still received a variety of counseling and health services in the 1970s, the massive increase in families under surveillance meant that the number of children in foster and institutional care ballooned from 177,000 in 1961 to 503,000 in 1977, a 180% increase (Shyne and Schroder 1978: 34).

The Debilitation of the Children's Bureau

Funding and programmatic shifts reshaped child welfare practices on the ground. The final nail in the coffin of a population logic, however, came from above: the disintegration of the Children's Bureau as the central locus of influence over American child welfare. In line with managerial efficiency trends, HEW, the federal agency in charge of social services, was reorganized several times in the 1960s and 1970s. The Children's Bureau shifted along with these changes, most radically in 1967-1969, when it was first moved under the jurisdiction of the Social and Rehabilitation Service (SRS) and then to the Office of Child Development. Along with this move to SRS, the Children's Bureau lost its well-respected bureau chief, now demoted to associate chief subservient to the SRS leader, and experienced a devastating staff reduction from 400 to 20 employees (Hutchinson 2002). With these reorganizations, jurisdiction over specific services was stripped from the Children's Bureau, including health, youth development, and social services assistance to state child welfare programs. Each of these functions was moved to a department that focused on similar issues across age groups, manifesting a logic of efficient welfare governance that focuses on problems, not populations.[59]

The population-focused paradigm did not die without a fierce fight. In a meeting with HEW secretary Robert Finch on October 10, 1969, representatives of multiple organizations representing children's and families' interests presented statements that expressed deep concerns at the fragmentation of the Children's Bureau's responsibilities among federal agencies for whom children were not the main priority. Barbara McGarry, of the American Parents Committee, read the following from a statement representing the organizations in attendance:

> The growth and development of children requires that all of their main needs be considered together. If they are separated and scattered among agencies whose main concerns and major activities are not directed towards children, good programs cannot be

[58] Funding foster care and adoption at the expense of family preservation remained a trend throughout the 1980s and 1990s, with growing backlash only beginning to have an effect in recent decades (Gainsborough 2010; Hutchinson 2002).

[59] An overview of the various re-organizations of the Bureau can be found at: https://www.archives.gov/research/guide-fed-records/groups/102.html. More discussion of these transfers can be found in Hutchinson 2002, Families et al. 2013, and Steiner 1971.

> expected…. It is difficult to find any consistent theoretical consideration behind the move. No integrative philosophy on the needs of children seems to be present."[60]

The advocates linked this concern to the idea that fragmenting programs usually meant that children's interests were subservient to the larger program focus. As Mrs. Jones (representing the National Committee for Children and Youth and the Council of National Organizations for Children and Youth): "… a program such as health services for children that becomes just a fragment of a major program will not get much attention. The only way to get major concern and major appropriations and major programing for children in this area is to have a focus, a spotlight on it, as it had while it was in the Children's Bureau."[61]

In a statement submitted to the HEW (and discussed during senate hearings in 1969) on behalf of the American Parents Committee, a law professor argued that the 1969 reorganization violated the original 1912 congressional mandate for a Children's Bureau to study and promote a comprehensive child welfare program: "Due to a loss of personnel and research funds, the newly defined Children's Bureau will not be able to perform the functions vested in it by act of congress. Although the bureau as a name is retained, its contents are totally gutted to a point of dishonest labeling."[62] Once stripped of most of its former child welfare functions, the primary issue that remained under the Children's Bureau's jurisdiction was the only one no other departmental agency focused on: research and program development related to child maltreatment, foster care, and adoption, for which a skeletal staff remained. From a sprawling agency with multiple research and advocacy agendas that collectively promoted a population-focused logic of child welfare, the Children's Bureau now became a maltreatment-focused shadow of its past.

There were two major implications of these changes, each of which profoundly undermined the Children's Bureau's influence over child welfare: the end of state agencies as clients, and the destruction of its research and publishing power. First, the Children's Bureau's child welfare state grants program was transferred to the SRS, which largely ignored the program's purpose—to guide state agencies in providing services—and focused instead on financial aid (Hutchinson 2002). The loss of the Children's Bureau's primary clients, state child welfare agencies, meant the erosion of the main centralizing element of the nascent child welfare infrastructure: the Children's Bureau's rehabilitation-focused guidance to a far-flung system of local agencies. It also demonstrates the complexity of infrastructural capacity's role in welfare governance evolution. Whereas a single agency in the federal government could be largely dismantled in a relatively brief time, it was far more challenging to take apart a widespread system of offices across the United States, with thousands of staff members, multi-level authorities, and funding grants. They were instead reoriented to deal with the most pressing issue of its time, and the one that was relatively best funded: child maltreatment.

---

[60] National Archives and Record Administration, RG 235, Box 5, October-November 1969. "Transcript of Proceedings, DHEW, Meeting of Robert Finch with the American Parents Committee Inc.," October 10, 1969, p. 18.

[61] National Archives and Record Administration, RG 235, Box 5, October-November 1969. "Transcript of Proceedings, DHEW, Meeting of Robert Finch with the American Parents Committee Inc.," October 10, 1969, p. 22.

[62] National Archives and Record Administration, RG 235, Box 5, October-November 1969. "Memorandum on the Reorganization of Child Health and Welfare Program," October 13, 1969.

This reorientation was partly the result of a convergence of administrative reorganization with legal advocacy for child protection laws. The loss of Children's Bureau guidance began in the late 1960s, just after all fifty states had passed mandated reporting laws (by 1967), with no federal support to help respond to vastly increased reporting. Instead, child welfare agencies, while still dealing with a wide range of service needs, were left to contend with a firehose of child maltreatment reports, but without the tools, mandate, or even guidance to provide the multi-service family-focused response that had long been the Children's Bureau's framework. A child welfare researcher described the result of the Children's Bureau's decline in 1974:

> "The Children's Bureau was the primary and, generally speaking, the only source of advice and consultation for child welfare administrators and their staff. New administrators now have no resource within the public welfare system to provide them with the basic concept of an integrated and comprehensive public child welfare program, or to give them information or advice on technical problems, established practice, development of new services, etc" (Oliphant 1974).

A second major result of the disempowerment of the Children's Bureau was the destruction of its staff and research power, which dramatically changed the production of knowledge about child welfare. The Children's Bureau's internally produced publications, which had covered a wide array of topics and had been sent to agencies across the United States, largely ended, due to lack of funding and research staff. Instead, the Children's Bureau was reduced to outsourcing research largely to outside contractors, including private non-profits, whose agenda was far narrower than the Children Bureau's had been. Whereas the Children's Bureau had focused on a wide range of issues, evident in their diverse publication topics (see Figure 1), smaller non-profit organizations like the American Humane Association had resources and advocacy experience only in their primary issue of interest: child maltreatment.

Beginning in the mid-1970s, the Children Division of the AHA, partially funded by HEW, produced annual surveys of state reports of child maltreatment. AHA was supplanted by the non-profit National Center to Prevent Child Abuse (NCPCA) in the mid-1980s, which was in turn overtaken by the federal National Child Abuse and Neglect Data System (NCANDS) in the 1990s—all of which used similar data: rising reports of child abuse and neglect to state-level agencies. The publications on these reports elaborated the meaning and implications of child maltreatment specifically, and in the process, transformed what had previously been a range of child welfare issues into one narrow category of child maltreatment (Gil 1970; Raz 2017).[63] A comparison of these reports to previous child welfare reports illuminates this change: both the Jeter reports in the 1960s and the Shyne and Schroeder report in 1978 (the primary comprehensive surveys on child welfare services during that era) separated health issues and parental wellness issues from child maltreatment, but the 1979 AHA report, which focused entirely on child maltreatment, presented such issues (as well as poverty-related problems) as "stress factors" for abuse (AHA 1981: 58-59). While early AHA reports discussed poverty as strongly correlated with substantiated cases of child maltreatment, this focus faded in the coming years and mostly disappeared in the NCPCA and later NCANDS reports, which focused as child maltreatment as an individual parent/child problem, largely decoupled from structural inequalities. This trend shifted child welfare away from a rehabilitative, family-focused

[63] See "National Analysis of Official Child Neglect and Abuse Reporting" reports published by the American Humane Association from 1976-1987.

paradigm to a narrow, problem-focused paradigm that set up parents and children's interests in opposition to each other. In effect, such a problem-focused paradigm funneled what was once a variety of issues that child welfare addressed into a narrow concern with parental maltreatment of children. This contracted jurisdiction was imposed onto a ballooning number of children that now fell under child welfare surveillance.

Policy Implications: Maltreatment as Funnel Effect

Child welfare's shift from a population focus to an increasingly single-issue one was reflected in jurisdictional changes on the ground. In her report on a 1974 study of child welfare in eleven states, CWLA researcher Winifred Oliphant attributes what she calls the "disorganization" of child welfare to multiple changes, including the "removal of the Children's Bureau from the federal public welfare administrative structure," the separation of services and financial aid that resulted in the merge of family and child services, the 1974 funding caps, and the general breakdown of state-federal relations. The result for most of the states she studied was, she argued, a rising emphasis on protection overtaking a fragmented and depleted child welfare infrastructure:

> At the state level, the merging of family services (to AFDC families) and child welfare services has resulted in a reduction in staff and responsibility, if not in the disappearance of child welfare administrative structures. Former directors of child welfare are mostly in charge of foster care and little else. In several states the changes have resulted in curtailment or disappearance of services to children in their own homes. (This has also been a byproduct of the recent interest—expressed in specific legislation in many states—in child protective services, child abuse, etc. That is, protective services may be very narrowly construed, and become the only accepted basis for services to children in their own homes, with the result that what is sometimes called preventive services—that is, service to families and children where there are problems of child care, parent-child relationships, etc., but no crisis of neglect or abuse—are abandoned.)" (Oliphant 1974).

This article was written shortly before the Child Abuse Prevention and Treatment Act (CAPTA, P.L. 93-247), the first federal law that focused entirely on child maltreatment, went into effect in 1974. Advocates fearful of a conservative backlash during the Nixon administration promoted the law by arguing for a "classless" notion of child abuse, delinked from poverty and racial inequality (Nelson 1984; Raz 2017).[64] In this way, the legal advocates that pushed CAPTA into law built on a cultural legacy of ignoring structural issues of poverty and racial inequality linked to maltreatment. While largely symbolic, CAPTA provided funding for research and minimal state programming that focused narrowly on parental maltreatment, with little funding for family interventions, while foster care remained an open-ended entitlement. Strongly critiqued by CWLA director Bill Lunsford and others as a cosmetic fix for a multi-system

[64] This was a response to the racialized backlash to the growth of racial minorities as beneficiaries of public assistance programs. Child protection advocates involved in legislative advocacy, concerned that protectionist legislation would not pass if the prototypical child abuse victim was African American and/or poor, instead promoted a notion of child abuse as commonly committed by psychologically damaged middle class white parents, inflicted on innocent white children (Nelson 1984). As shown in Chapter 3, this shifted in the late 1980s, specifically in coverage of the "crack baby" or substance-exposed infant, who was typically portrayed as an African American child of an uncaring and pathologically abusive mother.

problem (Children's Bureau 2014: 8-9), CAPTA in effect intensified the jurisdictional contraction of child welfare.

This narrowing jurisdiction, however, extended to the same population over which child welfare had already expanded its infrastructural reach: primarily poor families (DHEW and AHA 1979: 33). Figure 7, a copy of a figure published in report on the 1977 survey of child maltreatment reports, demonstrates quite clearly the powerful correlation between poor families and substantiated maltreatment reports in that year. Yet, as noted above, data for this link was rarely provided in later maltreatment research by NCANDS or NCPCA, an omission that may indicate a professional evasion of the links between poverty and maltreatment reports.[65] This was in line with deeply rooted cultural schema and a policy legacy that de-emphasized comprehensive poverty relief, as the 1981 AHA report noted, "the CPS system is neither equipped nor intended to alleviate poverty"[66] (AHA 1981: 23). Figure 8 indicates the long-term implications of this change. In Figure 8, an analysis of topics discussed in the landmark *Child Welfare* journal from 1960-1990 shows that over time, discussions of poverty—some quite optimistic during the war on poverty in the 1960s (Winston 1966)—are largely displaced by discussions of abuse as a proportion of all topics discussed. Abuse mentions across all articles analyzed rose from 6 mentions, or 2.9% of all main topic mentions, in 1960, to 25 mentions, 20% of all main topic discussions, in 1990, even though the number of articles declined from 1960 to 1990. Poverty rose from 10% to 17% from 1960-1970 (21 to 31 mentions) and then declined sharply to only 9 mentions (7%) in 1990. Of the thirty-nine articles that did discuss poverty from 1980-1988, thirty discussed them in context of abuse allegations. Neglect, however, remains fairly flat, and qualitative analysis, supported by previous scholarship (Lindsey 2004; Pelton 1978), indicates that neglect (the majority of maltreatment reports) is consistently linked to poverty throughout the decades, either because poor people are more likely to experience surveillance or because of more frequent occurrences of behaviors deemed neglectful, such as "lack of supervision," in which children are left unsupervised, often due to a lack of childcare resources in poor families. As noted below and discussed at length in Chapter 4, this was not necessarily because poor families were inherently more neglectful or abusive, but at least in part because resources for assisting them with those issues declined, even as maltreatment interventions and resources for child removal increased. Because families of color were overrepresented among poor families, by extension, they were also overrepresented among child welfare cases. Indeed, minority children were massively overrepresented among foster care placements, reaching 47% in 1980 (Freundlich and Barbell 2001). Ultimately, this reinforced a shift of child welfare's expanded resources to intensive surveillance and intervention of poor families, disproportionately of color.

By the 1980s, earlier optimism about erasing poverty was largely replaced with struggles over how to assess child maltreatment and foster care issues. The focus on maltreatment built on the cultural traces of a rehabilitative logic that seeks to transform structural inequities into individualized problems, solvable through individualized solutions. Child welfare was still animated by a ghost of its past rehabilitative logic, but now narrowed to only one issue to rehabilitate: parental maltreatment of children, with fewer available supportive solutions for families. And due to greater infrastructural capacity, its reach was much wider than it had ever

[65] See data

[66] CPS is an abbreviation for child protective services. By the early 1980s, the term CPS was often used interchangeably with child welfare services, signaling how protective services, which had originally been a sub-category of child welfare, had essentially merged with it.

been. The Adoption Assistance and Child Welfare Act (AACWA, P.L. 96-272) of 1980 sought to strengthen and better fund family preservation services, but funding for foster care greatly outstripped it, a consistent pattern throughout the 1980s and 1990s (Gainsborough 2010: 33). A significantly expanded child welfare infrastructure now provided services to multiple regions and populations, but nearly all issues but child maltreatment, foster care, and adoption were significantly cut.

Child welfare's jurisdictional narrowing was not a quick or clean shift. Scattered statements from child welfare researchers and organizations indicated a continuing belief in rehabilitative and population logics (Shyne and Schroeder 1978; USDHHS 1990), and agencies still focused on issues like health, childcare, and counseling in the 1980s. But these constituted a declining focus in relation to child maltreatment, as mandated reporting laws and growing public awareness inspired a skyrocketing number of child maltreatment reports. Simultaneously, federal, state, and local funding for child welfare and other social services for needy families gradually decreased as a proportion of welfare funding beginning in the 1970s (Moffitt 2015), even as child welfare funding rose, primarily for foster care and adoption services. These structural shifts set the groundwork for child welfare's transformation into a profession predominantly focused on child maltreatment by the 1980s,[67] a jurisdictional contraction that had a funnel effect of transforming issues of socioeconomic and racial inequities into concerns about parental maltreatment of children.

Conclusion

The transformation of American child welfare is a case study of how infrastructural capacity and jurisdiction can interact to trigger a paradigm shift in welfare governance. Based on this chapter's findings, I argue that the authority to implement policy constitutes both jurisdiction—the specific issues, populations, and spaces in which regulators can intervene—and the infrastructural capacity that enables interventions. The relationship between infrastructural capacity and jurisdiction is recursive, not causal, with each shaping the other, and each independently influenced by evolving administrative logics that shape the values and framings of professional and state administrative actors. In this reading, instead of advocates constructing ideologies of jurisdiction (i.e., that state and professional actors should intervene in families) that then motivate infrastructural expansion of the welfare system, infrastructural expansion that was originally supported for one purpose—to serve a population—can enable expanded jurisdiction of a different nature—to address a problem. This framing enables us to go beyond conceptions of the welfare state as a surveillance power to considering what such surveillance means—what forms of jurisdiction and infrastructure enable it and what shapes the gradual development of both of these elements. The case of child welfare illuminates how the overlapping development of infrastructural capacity and jurisdiction transformed an aspirational vision of comprehensive children's services to one focused primarily on child maltreatment.

This framing sets the groundwork for exploring two important implications of the funnel effect of child welfare's jurisdictional contraction: First, the narrowing of jurisdictional authority also simultaneously reinforced child welfare's legitimacy as an independent authority, not simply a sub-field of social work, which specializes in child-parent relations. In practice, this meant that

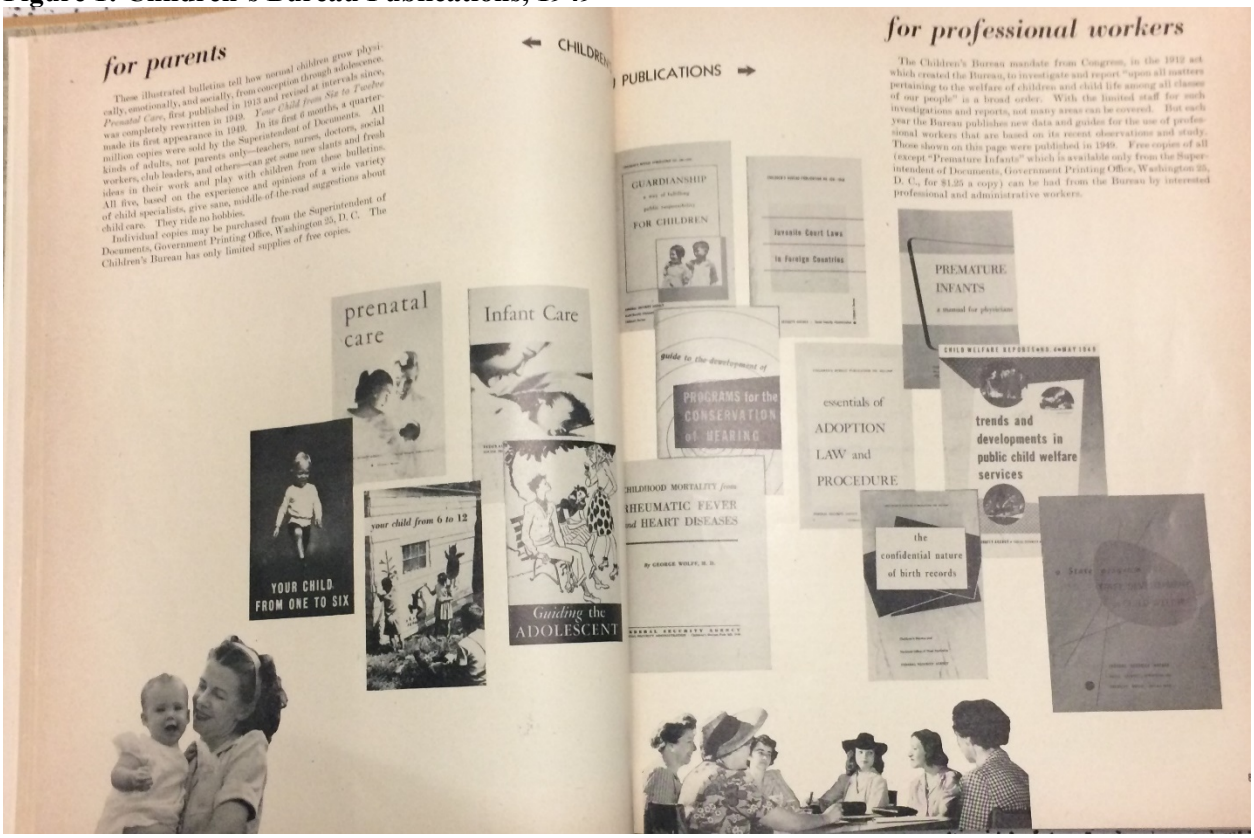
[67] Note that there were multiple attempts to push back on this paradigm from individual child welfare researchers and practitioners, but these made little headway against prevailing trends (see Chapter 2 of Raz 2020 for some of these efforts).

with expanded infrastructure and laws empowering their intervention, child welfare agencies had the symbolic capital to assert their authority to intervene in families, but they did not have the authority or resources to address underlying issues of poverty and systemic racism. This contradictory mixture of empowering and disempowering conditions encapsulates the dilemmas faced by social workers and child welfare agencies. No matter individual workers or agencies' commitment to improving families' lives, they were severely constrained by policies and funding restrictions set by legislators and by a diagnostic model of child welfare influenced not only by medical professionals, but also by child welfare's own roots in the casework method.

A second important implication of the funnel effect of jurisdictional contraction was an increasing focus by child welfare agencies and researchers on the risk of maltreatment, now the primary jurisdiction of child welfare agencies. The next chapter shows that the ultimate outcome of this emphasis on risk was a disproportionate focus by child welfare agencies on families most likely to experience high risk conditions—poor families, minority families, and families with health issues such as drug use. Ultimately, the data presented in these chapters help explain what current scholarship cannot: how and why child welfare shifted from a population to problem focus and the impact of that shift on the families most affected by maltreatment investigations.

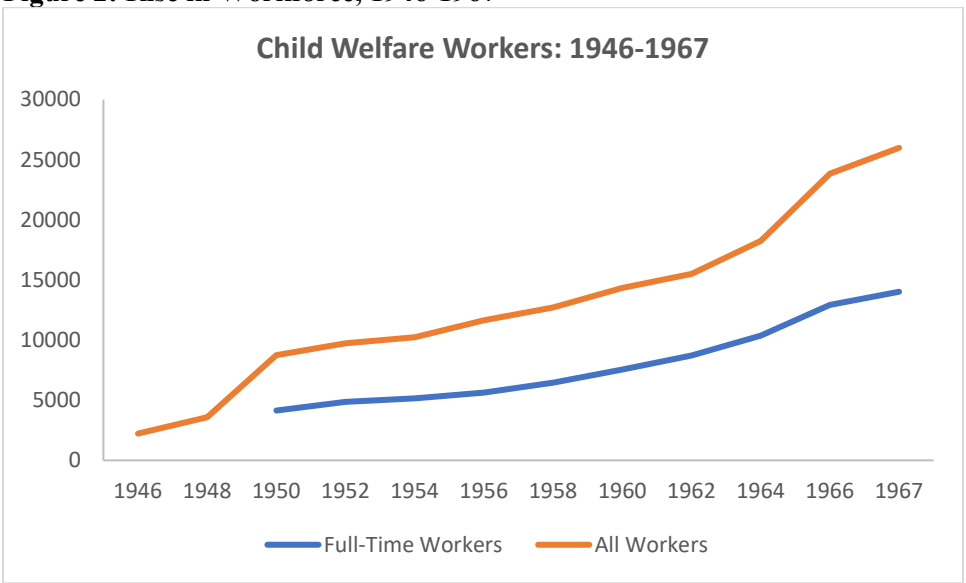
Figures

Figure 1: Children's Bureau Publications, 1949



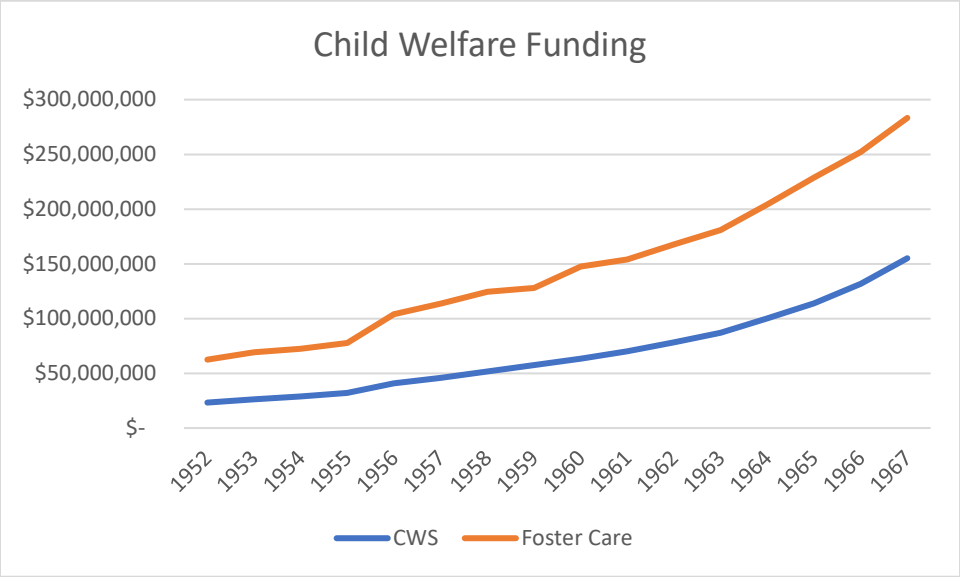
An array of Children's Bureau publications promoted in 1949 for both parents and professionals.

Figure 2: Rise in Workforce, 1946-1967



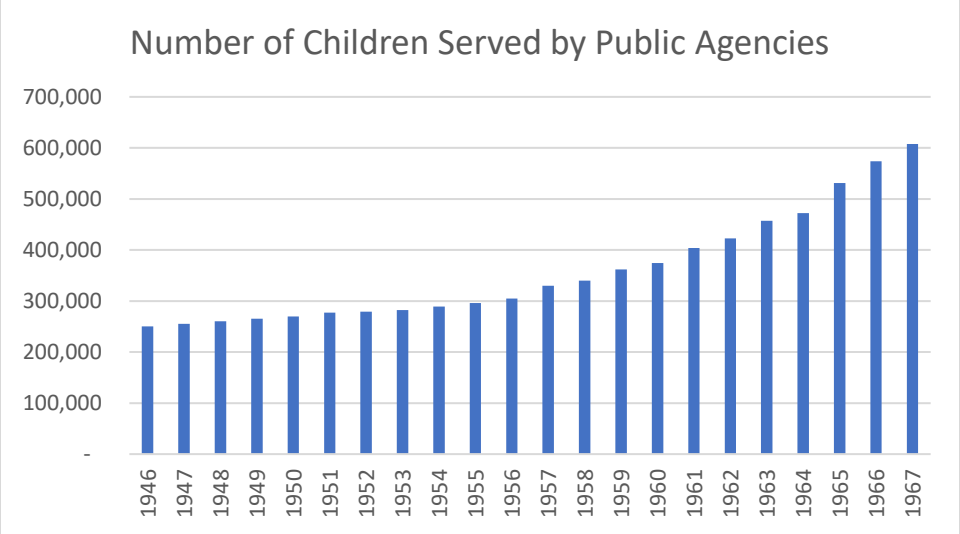
Source: "U.S. Children's Bureau Statistical Series," 1946-1967

Figure 3: Rise in Funding, 1952-1967



Source: "U.S. Children's Bureau Statistical Series," 1946-1967

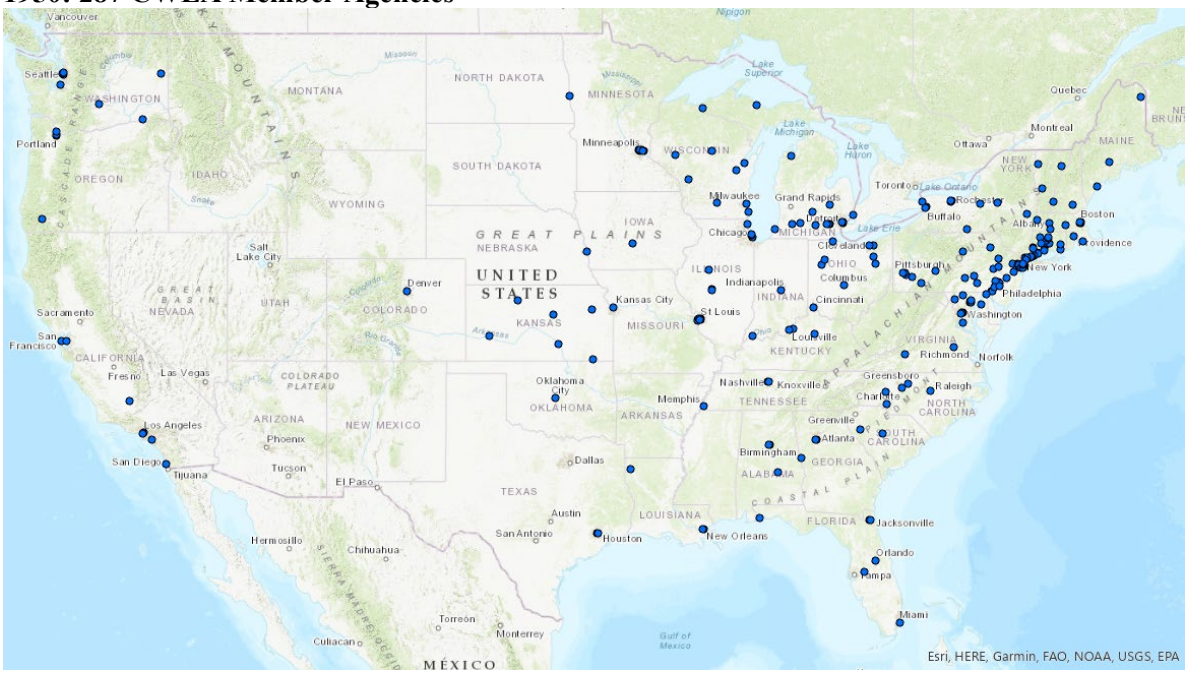
Figure 4: Rise in Caseload, 1946-1967



Source: "U.S. Children's Bureau Statistical Series," 1946-1967

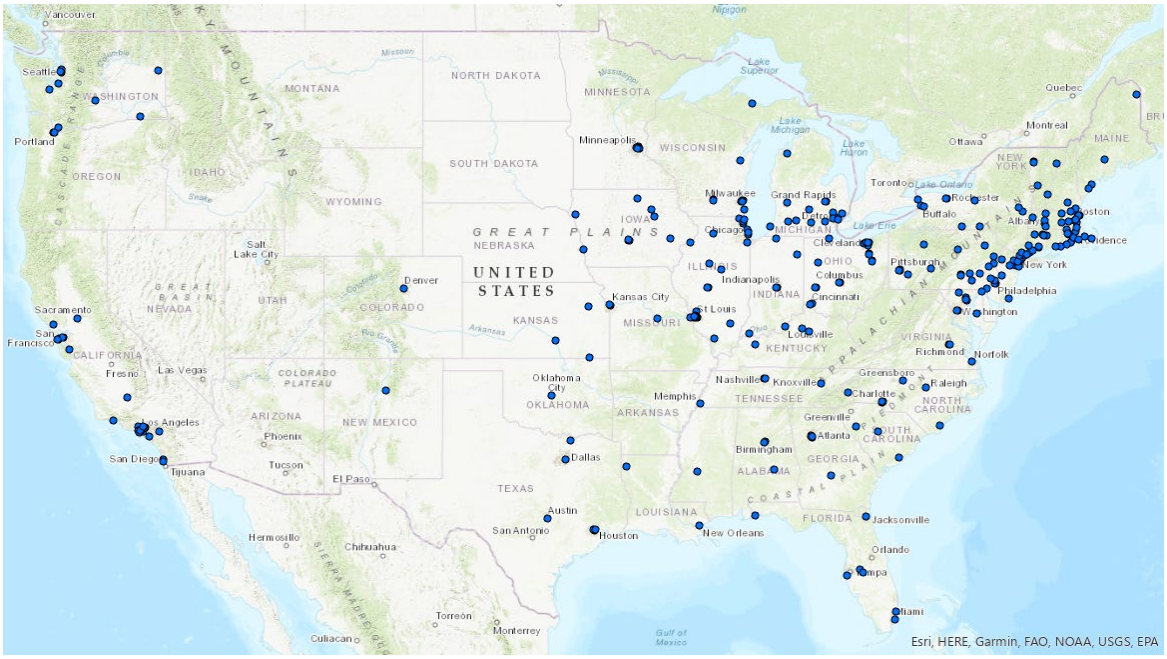
Figure 5: CWLA Agency Maps, 1950, 1961, 1971

1950: 287 CWLA Member Agencies



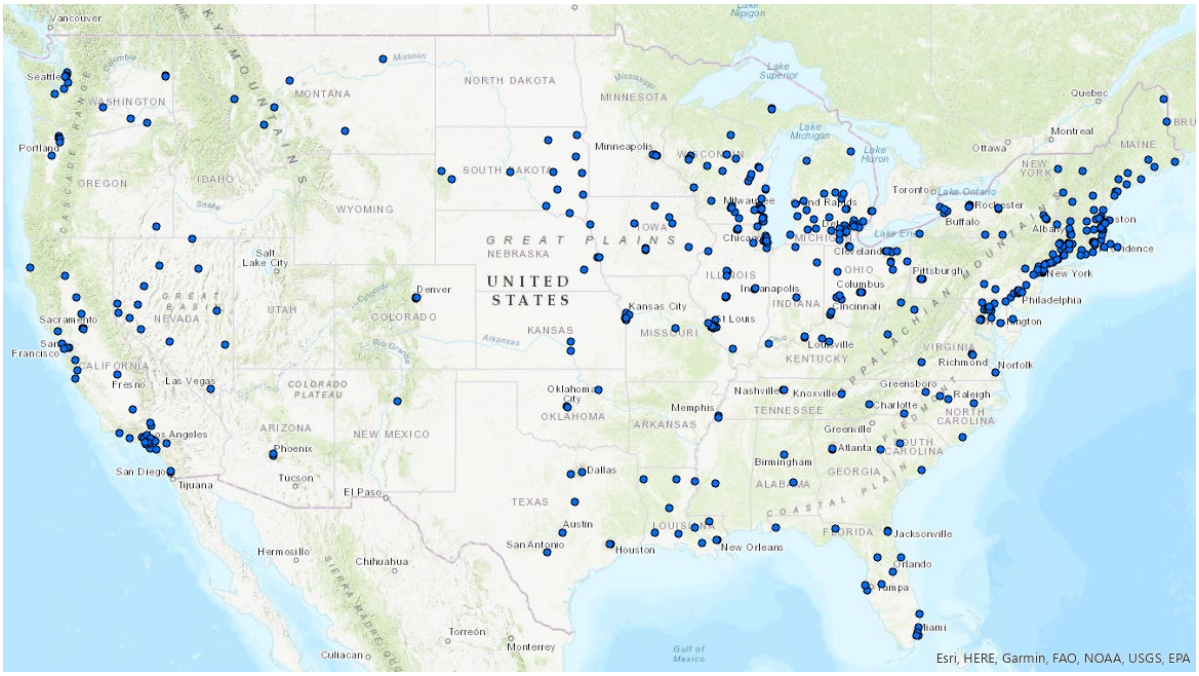
Data published in the 1950 Directory of Members, *Child Welfare League of America Inc., New York, NY, 1950.*

1961: 361 CWLA Member Agencies



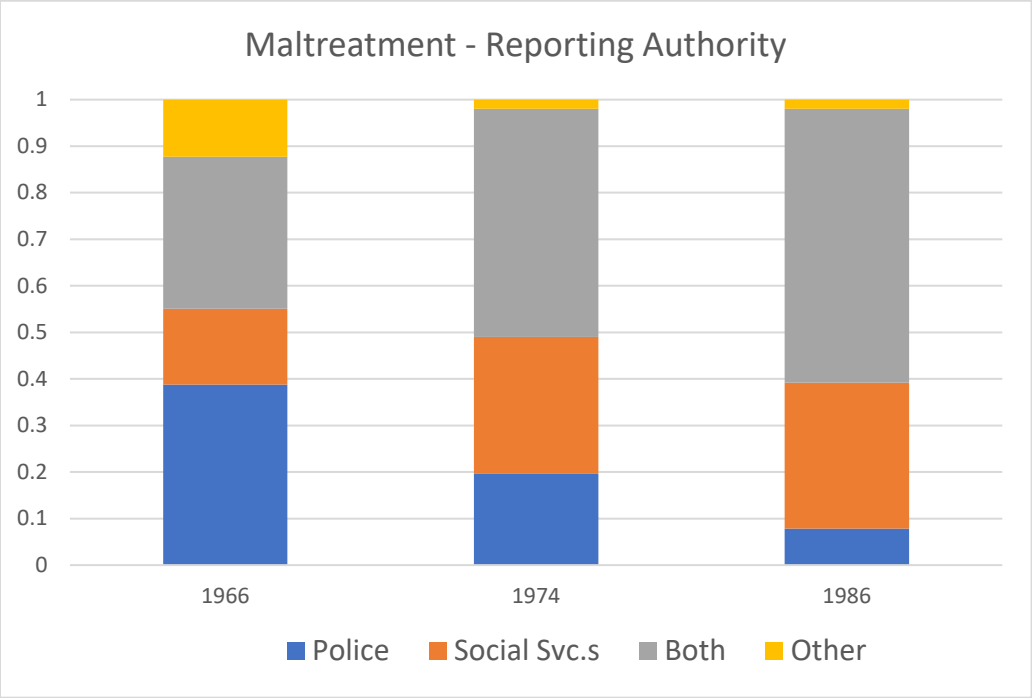
Data published in the 1961/1962 Directory of Member Agencies, *by the Child Welfare League of America Inc., New York, NY, 1961.*

1971: 596 CWLA Member Agencies



Data published in 1971 Directory of Member Agencies and Associates, *Child Welfare of American Inc., New York, NY, 1971.*

Figure 6: Law Enforcement and Social Services as Mandated Authorities



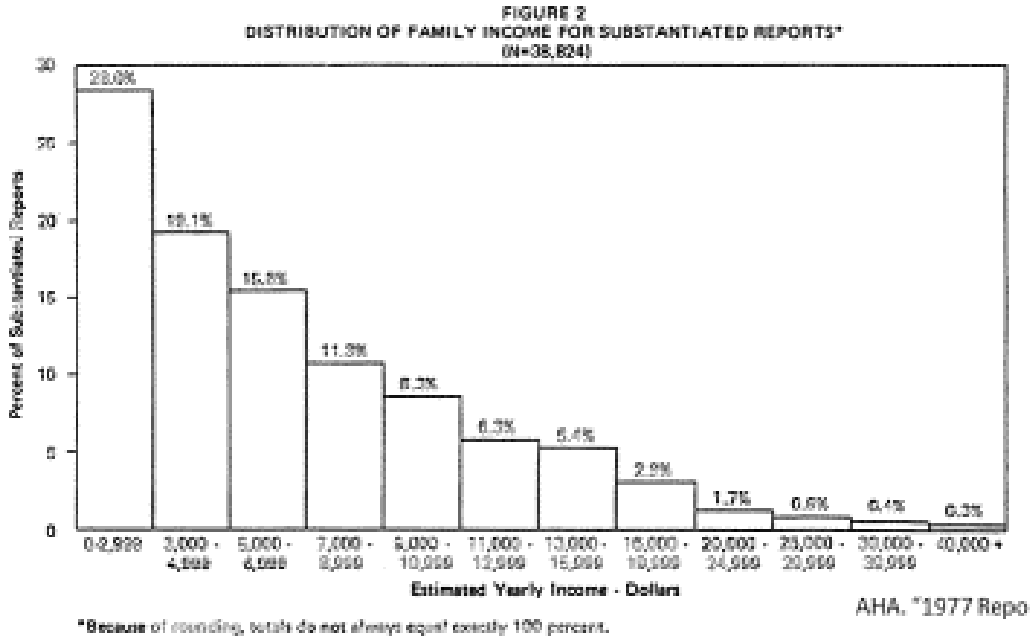
The percentage of states that mandated each authority type to receive maltreatment reports, by decade-representative year. Note that social services generally included child welfare services.

Table 1: Law Enforcement and Social Services as Mandated Authorities

Year	Law Enforcement	Social Services	Both LE and Social Services	Neither LE nor SS
1966	19 (39%)	8 (16%)	16 (33%)	6 (13%)
1974	10 (20%)	15 (29%)	25 (49%)	1 (2%)
1986	4 (8%)	16 (31%)	30 (59%)	1 (2%)

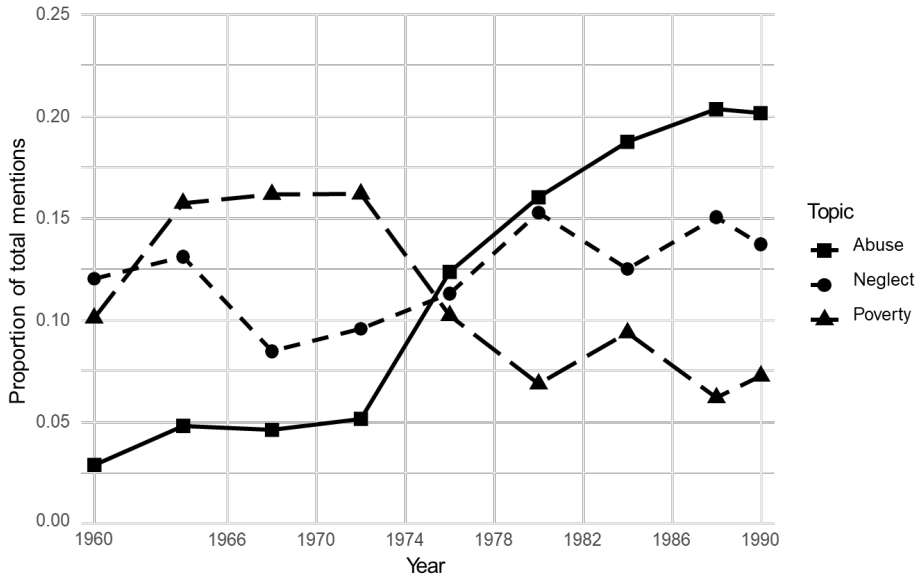
The number and percentage of states that mandated each authority type to receive maltreatment reports by year. Note percentages may not add up to precisely 100% due to rounding.
Source: Children's Bureau 1966; De Francis and Lucht 1974; Myers 1986.

Figure 7: Poverty and Child Maltreatment Link, 1977



AHA. "1977 Report." 1978

Figure 8: Child Welfare Discourses, 1960-1990



Data based on author's discourse coding of Child Welfare *journal articles from 1960-1990.*

CHAPTER 4. THE FUNNEL EFFECT: CONSTRUCTING RISK

Introduction

The jurisdictional contraction of child welfare in the late 1960s and early 1970s brought with it a new set of challenges to the child welfare profession. A narrow focus on maltreatment triggered rising reporting and child welfare caseloads, which in turn spurred widespread development of risk-assessment instruments to prioritize and process mounting cases. A focus on risk developed in context of a broader shift toward risk assessment as an important mechanism for surveilling and regulating populations deemed as deviant and potentially harmful to society, especially in the criminal system (Feeley and Simon 1992; Pecora 1991). As I will show in this chapter, these instruments catalyzed a *funnel effect*, a mechanism that reinforced the profession's jurisdictional contraction, and which transformed issues like poverty, lack of healthcare, drug use, and other issues often linked to structural inequalities into risk factors for abuse and neglect.

In effect, these findings show how risk assessment shifted child welfare's focus from harm to the child's body to potential risk of harm in the child's environment. In this chapter, I will first explain the contextual factors that enabled this shift. I will begin with an analysis of child welfare journal articles from the 1960s that demonstrate how poverty and neglect are conflated in early rudimentary efforts at risk assessment, establishing widespread assumptions in child welfare, on which more formal tools were predicated.[68] I then describe policy developments in the 1970s and 1980s, including an expansion of mandated reporting that led to an explosive growth in case reports, as well as increased resources focused primarily on child removal; together, both of these developments expanded child welfare's infrastructure for interventions, albeit specifically oriented toward a contracted jurisdiction over maltreatment issues, specifically, loosely defined forms of abuse and neglect by a child's primary caretaker.[69] This context anchors a chronological analysis of formal risk assessment instruments, beginning with their roots in the 1960s, an explanation of early instruments in the 1970s, and their development and rapid spread in the 1980s and early 1990s, after which they remained fundamental to child welfare practice to this day. Finally, the chapter then presents critiques of these tools and the implications of these critiques for families. My findings will close with a section that links these risk-focused instruments with an expanding focus on risk and endangerment, and increasingly broad definitions of child maltreatment, both of which unfolded in child welfare in the 1980s.

The findings in this chapter will illustrate two important implications of risk assessment instruments: First, I show that many of the tools in wide use in the 1980s and 1990s were constructed on the basis of problematic data, poorly defined terms, and unproven assumptions, leading to general issues with validity, false positives, and reliability of these instruments. Early instruments often built on data drawn from child welfare agencies, which disproportionately focused on poor families, and incorporated frequently untested social worker assumptions, biasing the studies and undermining their reliability. Even instruments that appeared to perform well in independent evaluations often did not account for structural inequalities, in effect recasting these inequalities as evidence of parental inadequacy. While research indicates that

[68] For a more detailed analysis of my methods and analytic approach, please see the methodological appendix.

[69] Abuse was loosely understood as intentional infliction of violence or damaging behavior on a child, either physically, emotionally, or sexually. Neglect generally meant deprivation of the child's basic needs. Both fell under the broad category of "maltreatment." However, as shown in this chapter, understandings of these concepts shifted over time.

poverty may be linked to worse outcomes for children,[70] the development of a risk-focused paradigm both reinforced and responded to broader structural limitations on child welfare resources to respond to poverty effectively. The result was that both income and racial inequalities were greatly exacerbated in child welfare outcomes in the 1980s and 1990s, with poor families of color disproportionately affected by removals. Second, I show how these instruments allowed child welfare agencies to both expand and institutionalize a widening web of surveillance over disproportionately poor and minority families, both by incorporating multiple professional systems into child welfare reporting and assessment, and by building on expanding categories of risk during the 1980s.

This chapter demonstrates how continuing expansion of infrastructural resources—albeit oriented toward child removal—converged with the development of risk assessment tools as a funnel mechanism for extending child welfare's narrow jurisdiction over maltreatment to a growing population of families. The findings substantiating this claim provide the necessary backdrop to chapter three, by showing how a focus on risk assessment enabled child welfare agencies' later framing of prenatal drug use as a site of risk, legitimizing their jurisdiction over substance-exposed infants and their mothers.

The 1960s: Linking Neglect and Poverty in Child Welfare

Despite a gradual shift to focusing on neglect as a distinct expression of parental dysfunction by the early 1960s, research in that era indicate that neglect cases were often closely correlated with poverty. In a study of child neglect published in 1964, the author notes that families referred to agencies for neglect issues were generally poor, characterized by unemployment, financial assistance, and large families. Specific behaviors described as "frequently cited in neglect complaints in order of frequency" included: "excessive drinking, inadequate control or discipline, inadequate housekeeping, illicit sex relations of parents, and leaving children untended. The author notes that the predominance of poor families (with minority families also overrepresented) in neglect reports conflicts with the "psychodynamic orientation" of social work, referring to the rehabilitative approach of child welfare, which tried to disassociate family functioning problems from economic issues (Boehm 1964). As the article described:

> For the most part, the neglect families represent the most socially and economically disadvantaged sectors of the population and differ from the general population of the community in the significantly higher proportion of broken homes, minority group membership, and lower socioeconomic status (Boehm 1964: 459).

An acknowledgement of the intertwined nature of child neglect and poverty was linked to the inter-institutional and relatively more family oriented social service response to these issues. Such a response accounted not only for the child's well-being but for the family needs as a whole, usually filtered through multiple social service organizations. This was in keeping with the rehabilitative approach that was predominant in the 1960s (see Chapter 3). Families were often referred to child welfare services by public assistance agencies, and generally not—as became common later—by mandated reporters focusing only on abuse and neglect by a parent or

[70] Why and how child maltreatment reports are overrepresented among poor families are issues that are fiercely debated in current literature. This dissertation does not seek to intervene in these debates; instead this research is focused on tracking the origins of systemic shifts in child welfare that reinforced these disproportionate impacts on specific populations (Drake and Zuravin 1998; Escaravage 2014; Fong 2020; Jonson-Reid, Drake, and Kohl 2009; Laskey et al. 2012; Lindsey 2004; Pelton 2015).

a primary caretaker. The stated goal of child welfare services was to provide preventative interventions in "multiple-problem families," for whom intersecting stresses, such as single parenthood, poverty, and other crises converged and were linked to neglect (Boehm 1964: 463-4). As one *Child Welfare* editorial urged, the appropriate response to this was "social planning," especially financial assistance for families, which would prevent neglect, abuse, and delinquency" (E.E.G. 1964).

In practice, a significant number of children receiving child welfare services were in foster care in the 1960s, but that was frequently due to parents voluntarily relinquishing custody, often for short-term stays, due to poverty or illness (Bernstein 1966; Jeter 1963). In fact, a study of forty families serviced for neglect issues indicated that, unless workers had hard evidence of the impact of neglect on kids, courts were unlikely to authorize separations. As the authors noted: "psychodynamically based predictions of adverse future emotional development of children resting on casework inferences derived from parental character problems or inadequacies were inversely related to court decisions resulting in placement" (Weinberger and Smith 1966: 463). That is, justifications based on risk alone were insufficient for removal. In general, public attitudes during this period militated against severe preventative action. For example, in a study of professional organizations' responses to neglect and abuse in 1964, only 58% of survey respondents believed protective action was needed in a case where a mother punished her daughter by burning her fingers, a response that would have been less likely in later years.[71]

The 1960s, however, were a period of great flux, as awareness of child abuse and neglect grew, amplified by media coverage and mandated reporting laws. In 1960, no state had a mandated reporting law, and by 1967, all fifty did. The laws required professionals—primarily doctors at first, but gradually expanding to more professionals that engaged with children—to report even suspicions of abuse. This left child welfare agencies with the problem of figuring out which of these reports of potential abuse and neglect were substantiated by the evidence and warranted investigation and interventions. A small number of preliminary studies sought to conceptualize abuse and neglect (Elmer 1967; Simons et al. 1966), as part of a broader and sometimes methodologically flawed attempt to assess impact of parental behavior on child development.[72] In particular, some early studies sought to understand neglect, specifically the risks of both neglect and of related negative outcomes for children. In one study conducted in the late 1960s, low-income parents were divided into neglectful, adequate (non-neglectful), and "borderline" neglectful parents. The latter essentially meant parents who were at risk of neglect, though they were not studied separately, but were instead lumped together with non-neglectful parents and compared to neglectful ones. Neglect was strongly associated with material resources, such as adequate housing and sleeping arrangements for children. Importantly, this study recognized the potential of poverty to push parents to neglect, noting that different levels of situational stress was the main factor separating neglectful and non-neglectful parents: "On the negative side, it is not inconceivable that as the stresses of poverty continue to bear upon them, the adequate mothers of today's study may be the neglectful ones of tomorrow's" (Billingsley and Giovanannoni 1970: 204).

Yet, as a focus on maltreatment grew, other researchers sought to distill individual and psychological causes of neglectful parenting, decoupled from poverty. In another study in the

[71] Even the fact that this was seen as neglect, not abuse, differs from later attitudes, which generally considered physical injuries abuse.

[72] These included studies on an instrument known as PARI, a tool developed in 1950s to study parental impact on child development; it was found to be totally invalid by 1970s (Loewenstein 1973).

late 1960s, Polansky et al. pathologize poor women who neglect children as having "apathy-futility syndrome," essentially, socially withdrawn and lethargic in their personalities and in their childcare (Polansky et al. 1970), which they argue is not linked to poverty but to some psychological defect in these women. These different conclusions from studies conducted in the same period reflect the transitional phase of child welfare—shifting gradually from a rehabilitative to a maltreatment focus both in theory and in practice.

Because of the transitional nature of this period of risk assessment development in child welfare, terms shifted frequently. To help guide readers through the complex and often confusing process of risk instrument development, I have provided a table (Table 2) below with an explanation of terms used in this chapter, which are also defined in the text. Note that these are not necessarily formal definitions that child welfare workers would have used at the time but are based on my systematic interpretation of texts during this multi-decade period.

Table 2: Key Terms in Child Welfare Risk Assessment (1970-2000)

Child welfare had long struggled with defining and standardizing definitions of key terms and practices. As part of the turbulent transition to a narrow focus on maltreatment in the 1970s and 1980s, the profession struggled to redefine itself as more than a sub-specialty of social work, with a set of practices and goals that were uniquely its own. Risk assessment was a crucial part of that professional development. This chart provides a guide to key terms researchers and practitioners used, albeit often loosely and interchangeably, during the risk assessment tool development era.

Concept	Definition
Maltreatment	*Maltreatment* – an umbrella term that includes both abuse and neglect of a child by a guardian or legal caretaker, usually a parent. *Abuse* – national surveys (AHA, NIS, and NCANDS) use this term to refer to intentional infliction of violence or damaging behavior on a child, such as breaking bones, causing burns, or emotional damage. The term grew broader over time and included more categories, with a particular emphasis on sexual abuse in the 1980s. *Neglect* – surveys used this term to mean the deprivation of a child's basic needs, such as clothing, safe housing, food, emotional support, and supervision; lack of supervision became a particularly common application of neglect in the 1980s-present.
Services	*Universal Services* –the aspiration that all children should receive social, medical, and other services that address their basic needs. This was the guiding ideal of child welfare administrators and agencies in the 1960s and early 1970s, expressed as a rehabilitative logic (see Chapter 3 for details).

	Preventative Services – these were services intended to prevent future harm to children. This term increasingly came to mean services that would prevent child maltreatment, as child welfare professionals shifted to focus primarily on abuse and neglect in the 1970s onward. Preventative services often incorporated: *Family Services* – This term was commonly used until the late 1970s to refer to services focused on the entire family, not just the child's needs. After the jurisdictional contraction to focusing on maltreatment, family services were usually referred to as *family preservation services*, which were focused specifically on avoiding separation of children from parents by preventing abuse or neglect.
Screening and Risk Assessment (sometimes used interchangeably)	*Screening* – assessment that a report of child maltreatment was based on evidence and justified further investigation by child welfare workers. *Risk assessment* – assessment of risk that child will be maltreated in the future, or that maltreatment will recur. This assessment could take place at multiple points of the investigation of a report of child maltreatment.
Risk Assessment Tools	*Consensus tools* –instruments usually composed of a checklist of risk factors, often subdivided into degrees of risk. The factors were usually not statistically validated, and tools fared poorly in evaluation, but they were widely used until the 2000s. *Actuarial tools* – while similar in practice to consensus tools, the risk factors were tested for stasticial correlation with maltreatment outcomes. These tools generally performed better in validation assessments, became commonly used in the 2000s. *Computational/Algorithm tools* – using large amounts of child welfare data, computation tools provide a risk score for child maltreatment reports; use of these tools began in 2010s, though they are currently used infrequently.

Toward a Risk Paradigm: Case Growth and Policy Context

While some of the articles in the 1960s discussed above indicate an academic interest in child welfare in assessing risk of parental maltreatment, formal risk assessment was rarely used by social workers in this period. Several shifts in child welfare encouraged an increasing focus on risk assessment by the late 1960s and early 1970s. In this section, I will first describe shifts to the child welfare population, as well as cross-disciplinary trends that encouraged a risk-focused paradigm. I will then describe broader policy changes in American welfare governance that directly impacted child welfare's resources for responding to cases.

Caseload Growth: Administrative Shifts and Mandated Reporting

The first change was internal to child welfare: a massive expansion of the population under child welfare surveillance. This was due to two intertwined reasons. First, from 1967 to 1970, the child welfare service recipient population jumped significantly from about 800,000 to 2.9 million children (Children's Bureau 1968; DHEW 1972). While some of this growth was due to increasing resources, much of this massive jump was an administrative artifact; many of these cases were of children who had not previously counted as child welfare recipients despite receiving a variety of government services, but were now categorized as such in new surveys, based on administrative mergers of child welfare, AFDC services, and family services.

Second, mandated reporting laws led to a massive growth in maltreatment reports (see Table 3 and Figure 9). These reports were the result of increasingly broad mandated reporting laws, an issue that only intensified in the 1980s. State legislatures frequently revised their reporting laws to increasingly expand the number of professionals required to report suspicions of abuse or neglect, yet maintained vague definitions of what required reporting. The total number of particular kinds of professionals specified in state law as mandated to report suspected maltreatment rose from 186 in 1966 to 684 to 1986 (Children's Bureau 1966; Myers 1986). The American Humane Association (AHA) reports indicate that the percentage of maltreatment reports by professionals rose from 44% of the total in 1976 to 54% in 1986.[73] While we do not know the extent of compliance (and have some clues that compliance was initially not that high), these laws and numbers indicate a growing network of surveillance over families that engage with health, public assistance, and educational professionals.

The way the laws were written contributed to the growth of child welfare caseloads. The basis for mandated reporting was consistently vague. Definitions varied by state, with a universal assumption that mandated reporters should report anything that seemed like a possible indicator of maltreatment, leaving child welfare agencies to sort out the facts. While early child abuse literature primarily discussed cases of significant violence against children, including head trauma, injuries, and long-term cognitive defects, these laws, which were constantly revised to include an increasing number of professionals and types of maltreatment, required even

[73] Data on reporting for 1976-1986 can be found in the "Official Child Neglect and Abuse Reporting" reports by the AHA for those years. The AHA reports are available for 1976-1978 on Hathitrust; the remaining reports were obtained through a variety of sources; the dissertation author possesses full or partial copies of all reports for 1976-1986. Note that professional reporting of maltreatment remained roughly above 50% until the early 2000s, when it began rising steadily, reaching 67% by 2018. Reporting data can be found in state-level datasets available from National Child Abuse and Neglect Data System (NCANDS), 1995-2019. This data is usually reported in the annual *Child Maltreatment Report*, published by the Children's Bureau, Administration for Children and Families, United States Department of Health and Human Services, 1995-2019.

suspicions of neglect or abuse to be reported.[74] As one critic of this approach noted: "To some extent the mandatory reporting of suspected cases of child abuse is an attempt to extend the recognition of manifest cases to the recognition of manifest markers" (Daniel et al. 1978: 250). "Manifest markers" is another way of describing risk factors for abuse and neglect, as opposed to manifest cases, which, unlike markers, were direct indicators of abuse or neglect, such as malnourishment or broken bones. Mandated reporters received little training on how to determine such markers; instead, professional mandated reporters were essentially expected to perform a rudimentary form of risk assessment, to ensure that parental or child behaviors were indeed cause for suspicion and warranted reporting. Unsurprisingly, considering the broadness of these laws and the fact that reporters could be held liable for non-reporting, reports skyrocketed.

Research Trends: Risk and Child Development

In addition to the primary issue of an expanding population of cases, specific administrative and professional shifts in child welfare and adjacent professional fields helped encourage an increasing emphasis on risk by the 1980s. First, during that decade, risk assessment became an established aspect of other fields of governance, especially criminal justice, which sought to reduce risk of violence and recidivism rates as part of a larger "war on crime" (Feeley and Simon 1992; Pecora 1991); this chapter indicates that a risk framing was deeply influential in child welfare as well. Second, the specific content of child welfare programming was also influenced by both programmatic policies and a growing literature on the importance of early childhood development. Programs like the successful and popular Head Start emphasized this point, as did a growing literature, which built on existing decades-old scholarship on child development, to emphasize the increased impact of neglect in very young children. Risk assessment tools asked questions about the age of the child, assessing younger children as at higher risk of both abuse and of greater impact and trauma from abuse in later life (Halpern 1986; Jonquet 1956). By the 1980s, this was further linked to concerns around child fatalities due to abuse—even though this was a relatively low cause of child death compared to other causes (Lindsey 2004)—with younger children at higher risk for fatalities (Daro and Mitchel 1990).

Welfare Governance Trends: Expanding the Infrastructure

A final important contextual factor for the shift to risk-focused family surveillance relates to the broader welfare governance trends in the 1980s, which trended toward reducing welfare programming. Families most likely to be surveilled by child welfare—poor and minority families—were particularly impacted by growing anti-welfare sentiments in the Reagan era. This translated into relatively less funding for poverty relief and family services, which were oriented toward the entire family's needs, not just the individual child's. Yet this did not actually translate into fewer child welfare resources; in fact, child welfare funding grew steadily throughout the 1980s, but these resources were largely shunted toward child removal—whether for foster care or adoption. While family preservation services[75] funding shrunk, foster care remained an

[74] Presumably, the assumption was that mandated reporters did not have the training or resources to assess if actual child abuse or neglect was occurring, and out of an abundance of curation during a time that growing attention was paid to child maltreatment, legislatures and the Children's Bureau and other legislative models chose to broaden the parameters for reporting. This left the burden of assessing these reports to child welfare agencies.

[75] Family preservation services were based on the traditional model of family services, which focused on the needs of the entire family, not just the child. However, as child welfare focused increasingly on maltreatment, family

uncapped entitlement during those years, and consistently dwarfed funding for other services, in part due to efforts of child protection advocates to ensure foster care funding as an immediate response to abused and neglected children; for example, in 1994, federal family preservation funds stood at 60 million, while foster care was funded at 2.6 billion dollars (Gainsborough 2010: 30-33). This contrast was relatively consistent—there was a 450% growth in foster care and adoption funding from 1986 to 1996 (Green et al. 1999). This translated into a growing child welfare infrastructure with jurisdiction that was substantively focused on maltreatment, as the population of reported cases steadily grew. The funding structures meant that even as there was greater emphasis on assessing risk in the 1980s and 1990s, the response to these cases was increasingly likely to lead to child removal during those years (Wang and Daro 1997: 5). Even when individual social workers sought other solutions, these were the primary resources they had at hand.

The tension between helping families and protecting children through focusing on risk was evident in the gap between research and practice in the late 1970s. In the early years of this service population explosion in the late 1970s, child welfare administrators engaged in a heated debate about whether agencies should focus their resources on universal services for all children, or on helping the highest risk children (Daniel et al. 1978; Lauderdale, Anderson, and Cramer 1978: 244, 324). A focus on universal services, which indicated comprehensive services for all children, regardless of need, was in line with the decades-old rehabilitative logic of child welfare, which carried over during these years of jurisdictional contraction, (both through a casework-influenced focus on the individual instead of the larger structural causes of maltreatment, and in a continuing interest in providing relatively comprehensive services). Even those who sought a focus on high-risk children tended to frame it as part of prevention of child maltreatment and removal, not punishment (Lauderdale et al. 1978: 26, 57). Yet these arguments unfolded in conferences and journals, at a remove from the policy reality of social workers, where such aspirations were constricted by trends in funding, which was rising much faster for foster care than for in-home services, as noted above. This could be seen in the rising numbers in foster care, which rose rapidly in the early 1970s, declined briefly from 1977-1982 in the face of a backlash to this drastic rise,[76] but began skyrocketing again in the 1980s.[77]

As a 1997 report explained:

> The number of children who received services at home declined from 1,244,400 in 1977 to 497,100 in 1994. Comparable numbers of children were in foster care placement in both years, 543,000 in 1977 and 502,000 in 1994 (US-DHHS, 1997). This decline reflects

---

preservation services were oriented specifically at helping the family holistically in order to prevent child removal. (See text box for more elaboration on family preservation and other kinds of family-oriented services.)

[76] The current literature reviewed for this dissertation does not provide a convincing explanation for the decline in foster care placements in 1977-1982, which was then followed by increases throughout the next two decades. Raz (2020) argues that the decrease was partially a temporary response to an outcry about over-removal of children in the 1970s, but it's not clear why that outcry was initially effective and then faded. I would argue that these changes had more to do with a constant increase in funds for foster care and adoption, with underinvestment in family preservation (Cytryn 2010); even if there was pushback that temporarily tamped down foster care numbers, resources and infrastructural capacity determined policy outcome more than the stated goals of policymakers and welfare researchers, as well as non-profit activists, to preserve families.

[77] For foster care data, see "Analysis of 1989 Child Welfare Data," a report published in 1993 by the Department of Health and Human Services, Administration of Children and Family, Children's Bureau, Exhibit 1-1, "Children in Substitute Care, 1980-1989." This report analyzes data from the Voluntary Cooperative Information System, or VCIS, which was data collected on foster care in the 1980s and early 1990s.

> a child welfare system that has evolved from a broader based social service system into a system primarily serving abused and neglected children and their families. Despite the good intentions of reformers, this service system is increasingly relying upon foster care placement to protect children from harm. While 30% of the children served by the system in 1977 were placed in foster care, that percentage has risen to 50% today (Wang and Daro 1997: 5).

In practice, this means that funding and thus child welfare agencies' focus on prevention and family focused services declined, making universal services a seemingly unattainable ideal. Instead, resources focused increasingly on abuse and neglect, not broader children's welfare issues. The growing child welfare infrastructure, albeit one oriented toward child removal, converged with an increasing shift toward risk assessment, which, as I will show in the remainder of this chapter, functioned to funnel an ever-expanding array of issues into child welfare's contracted jurisdiction. The next sections explain the rise of formal instruments for risk assessment from the 1960s to the 1990s.

The Development of Risk Assessment Tools

In context of these administrative, professional and policy trends, child welfare agencies sorted through mounting reports, beginning in the late 1960s. As reports poured in, child welfare agencies had to screen them to decide which to investigate and how to determine services. Screening generally indicated the first step, in which front-line workers determined if a report warranted an investigation, and risk assessment indicated the method of determining risk that a child will be maltreated in the future; risk assessment that could take place at multiple points during the investigation process. However, these terms shifted and were sometimes used interchangeably. In an effort to address the growing dilemma of skyrocketing caseloads, some researchers began developing tools in the late 1960s and early 1970s, drawing on more established risk assessment protocols from fields like public health and criminal justice (Pecora 1991). The next section will review some of these early tools, highlighting how first, methodological flaws often rendered many of these tools unreliable, and second, how tools frequently funneled structural and environmental factors, such as poverty and family support, into parental shortcomings. The following sections show how these tools evolved, with only minor corrections for these issues. As the findings in this chapter show, an expanded infrastructure and a jurisdictional mandate focused largely on child maltreatment, supported by significant surveillance from multiple professional networks, shaped how risk assessment tools developed into the primary mechanism for processing child maltreatment cases.

Early Risk Assessment: Pathologizing Parental Behaviors

In 1969, the Child Welfare League of America (CWLA), the foremost organization representing child welfare agencies, launched a preliminary study to develop the first widely publicized risk assessment tool. Sponsored by the U.S. Department of Health, Education, and Welfare (HEW), with a detailed report published in 1972, this tool focused narrowly on the risk of placement vs. in-home services in a specific subset of child welfare cases related to child-parent issues (Phillips et al. 1972). The report reflected a growing concern with placements of children, even as, unlike later tools, this instrument did not focus specifically on child maltreatment, but included issues like truancy, poverty, and parental mental illness, more common issues in child welfare at the time. In this tool, the primary risk factor was, first, parental requests for placements, usually temporary and usually due to child behavioral issues or

parental health problems. This indicated a significant difference from later tools, in which child removals were usually not requested by parents but were instead generally imposed involuntarily upon them.

The Phillips tool sought to bring consistency to the placement decision-making process, which the authors viewed as problematic due to lack of consistency and individual biases among social workers making decisions with little accountability. This was to be accomplished by a questionnaire, which allowed social workers to ask parents under investigation specific open-ended questions and encouraged them to use the answers to make decisions. The authors tested this questionnaire on users twice, and found that even when workers utilized the tool, which was intended to make the placement process more consistent, it could predict less than half of actual placement decisions, highlighting its lack of reliability (Phillips et al. 1972: 80). This was unsurprising considering that the tool did not allow for quantification, or any clear way to consistently or systematically translate the interviewee' responses to specific services. Despite this, the authors and HEW recommended its use to social workers, presumably for lack of better options.

By 1978, a new tool sponsored by HEW was published, this time focusing primarily on child maltreatment and removal (Dukette 1978). This tool was later cited by at least one researcher as one of the earliest risk assessment tools (DePanfilis and Scannapieco 1994). Again, this was an open-ended questionnaire, and there was little discussion of validation of the factors assessed, or how to translate qualitative answers to the questionnaire into consistent services. Some of the questions focused specifically on deficiencies in the parents' childhood and whether they sufficiently recognized them as such.

Other tools developed in the 1970s, which, while not quite as crude, also focused on pathologizing parental issues. A tool developed by a multi-disciplinary team of researchers was refined throughout the 1970s and tested in different study settings (Gray et al. 1979; Kempe et al. 1976; Schneider, Helfer, and Pollock 1972). Researchers contrasted "deviant" or "abnormal" parenting with non-abusive parents, who were labeled "normals" in one study. This was in line with an approach toward parental inadequacies that had been the norm since the 1960s, and which sought to frame parental maltreatment, in particular neglect, as individual parental pathology, influenced by a medical and casework diagnostic model of treatment. However, the studies never clearly define the specific practices that constitute "abnormal" or "deviant" parenting, which are vaguely described as extreme and inconsistent behaviors, associated with a small number of child injuries (Gray et al. 1979).

The preliminary quantitative tool constructed by Schneider et al. used cluster analysis of a series of questions that were posed to mothers to assess risk of abuse. The best predictive risk factor of abuse was a parent who had herself experienced abuse as a child, echoing the assumptions of the Dukette tool (1978), and the studies found some consistent patterns that categorized the study subjects groupings into "abusive," high risk, low risk, and "best moms" groupings. The determination of these was, however, very unclear—while high risk parents were assessed based on several social service agency rankings, there is no explanation for how researchers selected abusive mothers, of whom there were only 14 (out of 267). The "best moms" were labeled as such by their children's pediatricians, who presumably assessed this on the basis of a few medical consultations a year.

Proxies for poverty featured in all of these and other tools during that time as risk factors for child maltreatment. Not owning a telephone was listed as a risk factor in one study (Gray et al. 1979), unemployment was a common factor (Milner and Ayoub 1980; Phillips et al. 1972), as

well as economic status (Dukette 1978). All of these were integrated into analyses of multiple factors through which social workers were meant to assess parental competence and risk of child maltreatment. In practice this meant that these tools encouraged workers to translate poverty into risk factors that could lead to interventions. While these tools did not fare well in evaluation, they still helped influence practices on the ground, as described in the next section.

From Theory to Practice: The Spread of Risk Assessment

In the early 1980s, researchers developed tools that sought to reduce some of the methodological problems with past instruments, although not with great success (see 'Risk Assessment Shortcomings' section below) (Milner et al. 1984; Milner and Wimberley 1980; Starr 1982). This research influenced the growing development and implementation of these tools by social work agencies in the 1980s. By the mid-1980s, risk assessment had moved from primarily the realm of academic research into the realm of primarily applied practice, with state and local agencies often building on prior research literature as they developed their own tools. A 1987 survey of child welfare agencies showed that risk assessment tools were used by a growing number of child welfare agencies, with eighteen states stating that they used a tool and another eleven reporting that they were developing risk assessment tools or guidelines (Tatara 1987a). This shift from academia to the field had important implications for the development of tools, as explained below.

In the spring of 1987, several organizations co-hosted the first conference focused on risk assessment, the "National Roundtable on CPS Risk Assessment and Family Systems Assessment," with similarly risk-themed annual conferences continuing until the end of the century (Tatara 1987a). The documents from the conferences and the reports on agency tools indicate two shifts in the use of risk assessment instruments: first, the tools—or at least researchers' understandings of their scope and limitations—became more sophisticated, accounting for the complexity of interrelated factors, as well as acknowledging the need for better validation processes (Pecora 1989). Second, the shift from academic research to agency research as the predominant source of tool development changed the evolution and applications of these tools. While earlier instruments developed by academics were more focused on distilling the parental characteristics linked to potential child maltreatment behaviors, state agencies emphasized practical implementation, seeking to develop tools that could substantiate if maltreatment had actually occurred, and if it had, the probability of recurrence. As a result, risk assessment instruments morphed into multi-purpose tools focused on both screening families to substantiate reports and on assessing risk to justify interventions and to predict maltreatment recurrence (Olmstead 1989; Wald and Woolverton 1990). This more practical approach sought, first and foremost, to reduce caseloads, better allocate resources, and to develop a replicable process to systematically link services to the assessment process, with the added goal of strengthening consistency and reducing subjective judgments of social workers through a relatively more transparent decision-making process. Yet these aspirations did not usually happen in practice during the first decades of risk assessment development.

In this context, risk assessment was conceived by researchers and agencies as a tool of prevention—intertwined with larger efforts to prevent abuse or neglect from happening by providing preventative and family-focused services. In practice, however, risk assessment was used for a wide range of goals, including child placement and other intervention services. Indeed, frequent conflation of screening and risk assessment led to critiques that tools were inappropriately used for very different goals (Wald and Woolverton 1990).

Institutionalizing Risk Assessment in Child Welfare

By the late 1980s and early 1990s, risk assessment was widespread in state agencies, although some researchers cautioned against too much enthusiasm (Pecora 1989). A 1987 report included a relatively nuanced statement that "risk assessment will not predict behavior accurately but will put some parameters around the randomness of errors in judgment and could be a context for the development of increased accuracy" (Schene 1987: 227, underlining in original) . These tools built on some of the academic literature, with 24 agencies in the APWA study (out of the 26 that provided information on this point) stating that they used prior literature, as well as other state tools, to develop their own. In one example, agencies cited the book that included the Schneider 1972 tool (analyzed above) as an influential study in their own tool development (Tatara 1987b: 429).

State agency research also shaped risk assessment development during this pivotal period. The APWA report found that the Illinois CANTS-17B tool influenced at least thirteen other states' development of risk assessment systems (Tatara 1987b: 428). The Illinois tool exemplified the most common type of risk assessment approach in that decade: the consensus-based tool. Consensus tools were usually comprised of a list of risk factors, which "expert consensus" found were linked with child abuse, yet these links were rarely statistically validated. Also referred to as "matrix" tools, consensus-based tools generally required social workers to assign a level of risk to each factor, such as 1-4 for no, low, medium, high risk. The workers would then have guidelines—albeit often quite vague ones—on how to translate the level of risk found for these factors into a decision-making process. The risk factors ranged from factors like the child's injuries to environmental conditions and caretaker capacities. As noted for 1970s, some of these factors were strongly correlated with poverty, such as poor home conditions and low income in the Illinois CANTS-17B instrument.

A second and initially less popular model of risk assessment tools was an actuarial one, which became more widespread beginning only in the late 1990s (American Humane Association 1999). While consensus and actuarial risk assessment instruments appeared quite similar in practice, the risk factors for actuarial tools were selected only if they were statistically correlated with later maltreatment incidence (Baird, Wagner, and Healy 1999), usually in a controlled study, instead of the best guess of experts. These tools were somewhat more narrowly focused on factors like parental behaviors such as drug use, age of child, and factors, like lack of childcare resources, that were not always explicitly about poverty, but might function as a proxy for such. By 1991, risk assessment instruments, despite methodological critiques (discussed below), were spreading rapidly, with 42 states having either implemented or experimented with one. In a 1996 APWA survey of 54 states, territories, and county agencies, at least 38 jurisdictions (out of 44 respondents) stated that they had established a risk assessment system (Baird et al. 1999; Doueck, English, and DePanfilis 1993).

Risk Assessment Shortcomings: Implications for Families

While risk assessment tools were developed in large part in response to overwhelming caseloads (Pecora 1991; Wilson 1989), agencies and researchers also viewed them as a way to reduce social worker bias and increase consistency in the decision-making process. This also became important, one legal scholar argued, as family courts began demanding more evidence before acceding to social worker recommendations. In effect, however, this meant overriding at least some social worker judgement, and asking workers to change the way they had done

assessment in the past (Wald and Woolverton 1990). Unsurprisingly this led to significant social worker resistance in agencies seeking to implement these tools (Johnson 1987; Strouse 1990). This meant that even if a tool was relatively well-designed, implementation posed an enormous challenge to those seeking to institutionalize risk assessment. Such tools may have been required by many agencies by the early 1990s, but they were not necessarily well implemented, if they were implemented at all (Downs 1990). As a result, lack of transparency, inconsistency, and social worker bias remains a very real issue, even in later decades (Scherz 2011).

Methodological Issues in Tool Construction: Reliability, Validity, and False Positives

Beyond implementation, serious methodological problems existed with these tools, some noted by contemporaneous scholars. One important issue that reflected problems with the very construction of these tools was poor sampling in assessment and validation processes. The Schneider tool (Schneider et al. 1972; Schneider, Hoffmeister, and Helfer 1976), which was cited as highly influential by state agencies in 1987 (Tatara 1987b: 428), was riddled with multiple methodological problems. One fundamental problem was the inconsistent and problematic ways that the researchers selected the study populations on which they assessed the validity of the results. The Schneider tool was tested on populations that were selected on the basis of judgments by pediatricians and agencies, but there was little clarity about how they established consistent criteria for subject selection, and the numbers of women in the different groups (abusive vs. at risk vs. non-abusive) were highly uneven (Schneider et al. 1976).[78] Other problems included the lack of controls for poverty and other structural inequalities, including health issues, and the broad cluster categories that overestimated risk, to the point that 20% in of parents in one study using the tool had "deviant attitudes" about child-rearing that were similar to that of "known abusers," even if they had no known incidents of abuse (Kempe et al. 1976).[79] In another study using this tool two thirds of postpartum women in a random sample (100 out of 150 randomly sampled from a total population of 350) qualified as "high risk" for "abnormal parenting potential" (Gray et al. 1979). Unsurprisingly, the study authors acknowledge serious issues with validity and reliability, and especially the potential for a high rate of false positives and false negatives (Schneider et al. 1976: 406). Despite all of these issues, this tool was widely cited in the development of state tools in the 1980s (Tatara 1987b; 428).

Other methodological concerns abounded: Many of these earlier tools, especially consensus tools, were rarely studied with proper control groups; while this was an ethical issue—researchers certainly did not want to expose children to abuse to achieve good control conditions—it still contaminated outcomes in a way that made it difficult to determine the predictive validity of risk factors (Pecora 1989, 1991; Rodwell and Chambers 1989; Starr 1982). Overlapping risk factors also raised serious problems when they were counted separately and of equal weight in instruments, without a clear way to assess which factors should count more than others and which are linked to common causes (Wald and Woolverton 1990). Finally, assessments of consensus tools—the most common tools until the 2000s—repeatedly showed them to have poor reliability and validity. Ironically, interrater testing showed relatively low

[78] Poor sampling methods were not limited to risk assessment studies during this period. One review of a book on families charged with "lack of supervision" a growing category of child welfare neglect cases, found that sampling was so poorly done as to render the results of the study completely invalid (Jones 1988).

[79] In the initial report on the tool, the authors contrasted the deviant attitudes of parents with the "normals"—defined as parents without such attitudes, language that reflected the pathologizing framing of parents at risk of maltreatment (Schneider, Helfer, and Pollock 1972: 272, 276).

rater reliability, with weak consensus among social workers about decisions made using these consensus-based tools (Baird et al. 1999; Hughes and Rycusa 2006).

The problems in consensus tools were fundamentally linked to their construction as based on social work "expert" assumptions about the links between specific risk factors and child outcomes. These assumed links were rarely tested for validity (Hughes and Rycusa 2006; Wald and Woolverton 1990). This is particularly vivid in the earlier tools. The Phillips tool (1972), one of the earliest risk assessment tools, was built on existing data on child welfare worker decision-making, specifically correlations between placements and clusters of family "risk factors." This presents a fundamental tautology in the tool construction process: even while acknowledging the biases and inconsistencies in social worker placement decisions, they reified these biases by using them to build a questionnaire that calculated risk on the basis of these social worker assumptions. The tool and the testing processes—from the Phillips tool in 1978 to the Schneider and the widely influential Illinois CANTS-17B tools—did not appear to control for biases against poor people or racial minorities, and considered solutions in context of parental psychology, not poverty-based needs.

Over time, agencies and researchers sought to resolve these issues by emphasizing "actuarial tools." While initially seen as more valid , later studies showed that actuarial tools were also problematic in practice: even when these tools began spreading in the 2000s, they were inconsistently enforced with little consensus on final decisions (Hughes and Rycusa 2006; Scherz 2011). Beyond implementation, one issue was that actuarial tools functioned as a way to classify families, and classification in categories with factors that are correlated to certain outcomes does not necessarily imply causation; this was largely because the population of families with some of these highly correlated factors was significantly larger than the population of abusing parents. This was also true of consensus instruments, and it meant that most risk assessment tools of both kinds were plagued with reliability issues, as agency reports occasionally noted (Hutchinson 1987). Indeed, most families classified as high risk were not found to actually re-abuse, indicating potential for a high number of false positives (Hughes and Rycusa 2006).

This brings us to perhaps the most problematic and deeply rooted issue with these tools: high false positive rates. As early as 1978, a group of physicians critiqued risk assessment tools, noting the high false positive rate (10%) even with the best of screening approaches, arguing that it could be as high as 85% in poor screening conditions, which would be "intolerable" to society (Daniel et al. 1978). Yet this problem persisted. A 1982 study of common risk assessment variables found that most had low prediction success, and that even those with higher correlation still resulted in a 32% false positive rate. Similar issues were found in a series of studies that developed risk assessment variables (Milner et al. 1984; Milner and Wimberley 1980). A 1987 meta-analysis of these tools found a 46% false positive prediction rate overall, though they found that some smaller studies have better (albeit still relatively high) rates (Pecora 1989: 52).

In response to these issues, some researchers and advocates evinced concern with balancing the dangers of false positives, specifically unnecessary interventions in family lives, with false negatives, in which workers would miss potentially dangerous situations (Mcdonald and Marks 1991; Wald and Woolverton 1990; Whipple and Webster-Stratton 1991). Others argued that it was better to err on the side of false positives. As Phillip Zunder, the Director of Planning and Evaluation of the Vermont Department of Social and Rehabilitation Services noted in a presentation at a 1989 conference on risk assessment:

> What is an appropriate balance of false positives and misses? The answer depends upon their relative cost, which is difficult to quantify. The cost of a miss would be based on child harm, up to and including death, and a variety of long-term effects. This cost is generally considered to be greater in magnitude than the cost of a false positive, which is based on services which might have been unnecessary and on the short-term and long-term effects of family disruption. As a result we might be less concerned about the consequences of false positives than about the consequences of misses. Better to err on the side of caution (Zunder 1990).

This perspective overlooks the point made by other articles, one that was not as fully acknowledged in the 1980s or 1990s: the interactions by even the most well-intended child protective services could be quite traumatizing and harmful to families and children, due to the power dynamic in which the threat of child removal was ever-present. And in the 1980s and 1990s, as child removals grew in number, it was a very real threat. It was only in the 2000s, as more work began covering the traumatic effects of child welfare interventions and their disproportionate effect on families of color, that this became a motivator for reducing interventions (Courtney et al. 1996; Fluke et al. 2003; Roberts 2002), but in the period that is the focus of our study, that was not a high priority. Indeed, methodological issues were sometimes framed as less problematic by report authors, who generally claimed these tools were only for evaluation, and that families should always be provided with options for in-home services. Indeed, multiple authors sought to situate risk assessment as part of a broader preventative approach, particularly in the 1970s and early 1980s (Ayoub and Jacewitz 1982; Gray et al. 1979; Rodwell and Chambers 1989). Some reports and articles explicitly recognized the trauma of separation and tried to avoid placement by urging that agencies provide resources (Dukette 1978). Yet the deeply uneven budgets for removals versus services often rendered that choice moot. Whom did methodologically flawed instruments most affect? As this next section shows, many of these methodological issues made these tools more likely to affect poor families, or families undergoing crises with few resources to address them.

Standardizing the Conflation of Poverty and Maltreatment

Beginning with the earliest tools, and building on prior assumptions in child welfare research, risk assessment instruments essentially institutionalized—by which I mean that the tools made standard in the field, so it became largely unquestionable—the conflation of poverty and neglect. The Phillips tool, sponsored by HEW and published in 1978, was an open-ended questionnaire, which did not appear to have been tested for validity or reliability. It was presented as a guide for social workers to obtain "objective understanding" that would enable them to determine if a child should be removed from the home. This objective understanding was based on a series of risk factors, including parenting challenges, child behavioral issues, and "family organization." The latter section, in a nuance that could also be read as a contradiction, included questions on both whether the parent had "supportive help from relatives" and whether the parent indicated "appropriate independence" instead of "continuing dependence" on relatives (Phillips et al. 1972: 21). The second question indicates a bias toward nuclear families and a pathologization of interdependent family cultures that are more common in poor families of color (Stack 1983).

Even more explicit pathologization of poverty can be found in tools that focused specifically on assessing neglect, published by practitioners for use, not simply research

purposes. In such tools, implemented in the late 1970s, factors that counted toward a score that would find families neglectful included poor house repairs, second-hand clothing, shared bedrooms with parents, unstable employment, and whether a parent takes a child fishing, to the movies, on overnight vacations, or owns a camera (Coombes et al. 1978; Polansky et al. 1978). In a 1989 survey of risk assessment tools and implementation in eight states, poverty was listed as a common risk factor for maltreatment (Cicchinelli 1990). More sophisticated tools were less explicit about poverty, and instead conflated situational "stress factors" with psychological factors. Examples of stress factors, however, might include "support for caretaker," a common risk factor in instruments (Mcdonald and Marks 1991), without accounting for how poor families might have less support. While accounting for poverty was important, considering the links between poverty and poor child outcomes, the structural obstacles to effective resources for assisting such families meant that they were more likely to face child removal or other invasive interventions than assistance that resolved poverty issues.

One significant issue was that many tools, especially those that focused on neglect, were tested on poor populations. The assumption was that this would control for poverty, allowing researchers to distinguish between neglectful and non-neglectful poor families. Yet researchers did not appear to consider the precarity of poverty, and the concerning ease with which, as Polansky et al acknowledged in 1964, poor families could shift from one category to another. In fact, one example of such a tool was by the same authors who had previously recognized this precarity—Polansky et al.—who by 1978 were testing a new theory of "apathy-futility syndrome" (discussed above) on an entirely poor population (Polansky et al. 1978). While they argue that using this population enables them to see how and why some parents are neglectful and some are not despite poverty, the psychological framing obscures what was clear in earlier studies: situational stress, generally associated with conditions of poverty, is a common factor to many poor parents, and the distinction between those deemed neglectful and those non-neglectful cannot so easily be de-linked from those stresses (Billingsley and Giovanannoni 1970; Boehm 1964). That is, the fact that many poor parents manage, often with significant struggle, to not lapse into despair—i.e. "apathy futility syndrome"—does not mean that the stresses of poverty cannot explain a significant part of why some parents do.

This was particularly problematic because neglect cases consistently constituted the majority of child welfare reports, yet abuse and neglect were often conflated in the risk assessment literature and practice. Neglect cases were frequently linked to issues of poverty or proxies for them. For example, a growing category of cases (examples of which are discussed below) was "lack of supervision," when parents holding down 1-3 minimum wage jobs did not have childcare resources and so left children at home alone. Abuse by contrast, constituted a much smaller number of cases, and often involved physical assault of children, an entirely different category of behavior linked with more significant harm to children.[80] Yet this slippery conflation was often unacknowledged or even denied by authors of instruments. Some argued that this conflation was valid (Milner and Wimberley 1979), while others simply stated that both

[80] Lindsey (2004) argues for distinguishing between the majority of cases, which involve relatively mild forms of neglect or abuse and are disproportionately linked to problems of poverty, and severe physical abuse and neglect, which he claims should be viewed as criminal assault.

neglect and abuse should be treated as equally problematic categories of maltreatment (Wald and Woolverton 1990), as indeed they were in surveys during the 1980s and still are till this day.[81]

Such conflation meant that while neglect was particularly disproportionate as an issue among poor families,[82] ultimately, maltreatment as a whole—because the majority of maltreatment reports have consistently been of neglect cases—became an issue framed as an individual pathology, despite strong associations with structural issues like poverty. This link was sporadically acknowledged by researchers, and even raised infrequently as a serious issue.[83] As one analyst wrote in 1986:

> A parent who cannot successfully meet her own primary needs is going to have a very difficult time meeting her infant's physical and psycho-social needs. Economic-insecurity, inadequate housing, lack of access to medical care, and related problems may seem more tangible and immediate to a parent than the nurturance of an optimal psychosocial relationship with the infant" (Halpern 1986).

Yet others evinced more ambivalence about the overlap between pathology and poverty, noting: "Child abuse will only become less of a problem in low income, multiple problem families when we develop ways of improving their quality of life in general and, more specifically, correcting the deficiencies in parent-child interaction patterns" (Starr 1982: 132.) Despite the sporadic and sometimes half-hearted recognition of the issue, tools continued to assess for neglect and abuse on a continuum or by conflating both, often decoupled from poverty (Tatara 1987a).

In effect this meant that cases of maltreatment were far more likely to occur among poor families. Indeed, the NIS 1988 study, a relatively representative study of child maltreatment incidence, showed that physical neglect cases occurred ten times more frequently among lower income families, and physical abuse was 5-7 times more frequent (5 for moderate injuries and 7.5 for severe injuries). This affirmed what the 1977 AHA study of child maltreatment reports had shown (see Figure 7 in Chapter 3): that maltreatment reports were highly correlated with poverty. Similarly, children of color were vastly overrepresented, constituting 60% of foster care placements by 1990, in part because families of color are overrepresented among the poor (Freundlich and Barbell 2001; Stehno 1990).[84] Practitioners repeatedly emphasize this issue in articles in the *Child Welfare* journal, noting, in articles stretching from 1960 through the 1980s and later, that child removal is used as a panacea for poverty (C.S. 1982; Schottland 1974; Winston 1960), finding that depression and child neglect was linked to poverty and poverty-related stress, instead of disassociating pathological parental behavior from poverty as some

---

[81] Both the NCPCA national surveys of child maltreatment (1986-2000) and the current NCANDS surveys, published in reports by the U.S. Children's Bureau entitled "Child Maltreatment" (1995-2019) refer to "child maltreatment" as including both child abuse and neglect.

[82] See the four-part National Incidence Study of Child Abuse and Neglect," published by the U.S. Department of Health and Human Services in 1980, 1988, 1996, 2010 for data confirming strong links between both abuse and neglect and low income status. This link was also made in research published in the *Child Welfare* journal in earlier decades (Boehm 1964, 1964; Pelton 1978; Wolock and Horowitz 1979).

[83] In 1981, the *Social Context of Child Abuse and Neglect* was published, an edited anthology of articles, building on previous work by Pelton (1978), about how an over-focus on psychodynamic aspects of child abuse and neglect obscures strong evidence of links to poverty (Pelton 1981). This point is reinforced by later work by Pelton (Pelton 2015) and Lindsay (2004).

[84] Questions of systemic and individual racial bias in child welfare are highly debated (Ards et al. 2003; Courtney et al. 1996; Dettlaff et al. 2011; Drake, Lee, and Jonson-Reid 2009; Jonson-Reid et al. 2009), and are not the primary topic here, though this research does strongly indicate that there are racially unequal outcomes in child welfare.

tools did (Kettner and Daley 1988; Kinard 1982; Polansky et al. 1978), that a "payday effect" meant an increase in maltreatment reports in the days before standard paydays for poor families and a decrease thereafter (Lobb and Strain 1984), and that neighborhood was a major predictor in whether reports were even investigated (Wells 1989).

However, while the overrepresentation of poor children receiving child welfare services is well-established, the population of low-income families with no reports of maltreatment was (and is) multiple times larger than the population with such reports. In other words, most poor parents never abuse or neglect their children and are never reported for it.[85] Yet considering the high probability of maltreatment investigations occurring in poor families, especially those of color (Kim et al. 2017), some researchers during this period (1980-2000) linked these outcomes to a lack of resources to deal with unemployment, health, and other poverty-related crises that arise (DiLeonardi 1980; Kettner and Daley 1988; Koerin 1980; Mcdonald and Marks 1991). That is, poor families—precisely because they are poor—are only one or two crises away from situations of potential neglect or even abuse, while higher-income families have the cushion and the protection of less surveillance to shield them from such interventions. As one researcher put it, "To a great extent, child abuse and neglect—especially neglect—are the products of poverty" with African American families particularly disadvantaged (Stehno 1990).[86]

Illustrations of poverty as a risk factor, disconnected from its context, can be seen in sample forms included in the 1987 conference on risk assessment report. The widely influential Illinois tool provided two applications of its tools, with sample forms filled out with case details. While presumably hypothetical, both of the cases show clear links to poverty. In the first, the family leaves their children occasionally unattended due to job obligations and lack of childcare resources; the child care service seeks to resolve this by asking them to have a grandparent watch the child, but there is little context on whether the grandparent is willing or available to do so. The report does not note any proposed intervention in which another childcare resource, or funding for such, is offered to them. In the second, a mother's live-in boyfriend physically bruises her 3-year-old child; she blames it on stress due to unemployment. This raises deep concerns about child safety and triggers further interventions to reduce risks of future abuse. In both cases, however, there is no discussion in the risk assessment forms of the obvious issue—these are poor families and their sub-optimal childrearing conditions, which might indeed put their children at risk for harm, are directly linked to their lack of resources. Instead, the poverty variables are transformed into risk factors for child maltreatment, triggering interventions focused on risk of parental harm to the child, without ameliorating their lack of resources with substantive support.[87] To be clear, this is in large part because child welfare workers did not

[85] While poverty is associated with worse outcomes for children, how to resolve these issues of poverty remains a matter of considerable debate (Barth, Wildfire, and Green 2006; Conrad-Hiebner and Scanlon 2015; Drake and Zuravin 1998; Pelton 1997, 2015; Rostad, Rogers, and Chaffin 2017; Yang 2015).

[86] Research has found consistent overrepresentation of minorities in child welfare investigations and interventions, yet the literature on the causes for that overrepresentation is deeply contested (Drake and Jonson-Reid 2011; Drake et al. 2009; Kim et al. 2017). The data in this chapter offers strong support for, at the very least, how structural factors like poverty, in which African Americans and other minorities are highly overrepresented, can lead to increased surveillance and poorer risk assessment scores.

[87] Note that many of these interventions did not end in child removal, but that child welfare interventions could also cause severe stress and harm, as well as potentially aid families, even if there was no removal. Moreover, during the period studied in this chapter, the 1980s-1990s, child removals were at an all-time high. Some scholarship link this increase partially to an influential 1973 book, *Beyond the Best Interests of the Child*, by Joseph Goldstein, Anna Freud, and Albert Solnit. The authors argued that the best interest of the child was a stable psychological bond, and

generally have access to the kinds of resources that would ameliorate some of these issues. Indeed, the convergence of broader governance norms that reduced resources with a narrowing jurisdiction over maltreatment resulted in a lack of effective responses to these issues.

Expansion of Child Maltreatment Definitions

There were two other factors linked to internal developments in child welfare that enabled risk assessment to expand surveillance of families and transform structural inequalities into parental inadequacies. The first was the expansion of child welfare into a multi-institutional/inter-system network of surveillance, described in detail above in the section on reporting laws. The second was an expansion of definitions of abuse and neglect that began in the late 1970s, picking up pace in the early 1980s, and provided important context for the spread of risk assessment tools in the 1980s.

This last section focuses on these shifting definitions, in particular their increasing emphasis on risk, directly or indirectly. Explaining how these definitions developed provides a broader context to expansion of risk assessment instruments, showing how widespread use of tools was part of a larger paradigm shift in child welfare from the body of the child to the environment of the child. Somewhat paradoxically, risk assessment instruments were partly an effort to develop and refine definitions of child abuse and neglect, in order to make them more consistent. Yet child maltreatment intervention norms were highly decentralized, with reports and investigations handled at the local level, influenced by fifty different state laws on mandated reporting, each with their own set of generally vague definitions of abuse and neglect. State-specific totals of maltreatment reports, based on this tangled confusion of definitions, were the basis of the earliest national surveys on child maltreatment, run by the AHA from 1976-1987, as well as those of the National Center to Prevent Child Abuse (NCPCA) from 1986-2000. This essentially meant that these numbers—while widely used due to a dearth of other data—were fundamentally unreliable: neglect did not mean the same thing in different states, so clustering all neglect reports was statistically problematic. Concerns with these inconsistencies led to discussions of refining definitions, even as, by the mid-late 1970s, researchers were expanding ideas of neglect, in particular concepts of emotional neglect, and the links between neglect (emotional and physical) and poverty (Polier 1976).

During this period, the federal government founded a relatively more rigorous and comprehensive survey, as compared to the state report surveys. This survey, the National Incidence Study (NIS), provides a clearer window into the evolution of definitions and how they were linked to expanding concepts of child welfare. The category of "child maltreatment" in the NIS expanded from a rigidly defined standard of "harm" in the first study conducted in 1979 to both "harm" and "endangerment" standards in 1986, indicating a shift in focus from the child's

---

that biological parents did not necessarily have a stronger bond than non-biological caregivers. This argument helped justify what was actually an infrastructural move—increased resources for child removal—by arguing that this was psychologically in the best interest of the child. The passage of the 1997 Adoption and Safe Families Act (ASFA – P.L. 105-89) encouraged many states to shorten timelines for family reunification and find alternative placements that permanently separated children from their parents. This shift away from parental rights, some scholars claim, is an important framing point in child welfare development in the 1980s and 1990s (Reich 2005). I would argue that this was not really a new perspective. Child welfare—or their charitable non-profit counterparts—had been taking away children from poor parents for more than a century at this point, and legislators (both state and federal) were consistently more open to funding foster care more than to supporting poor families (Abramovitz 1996; Gainsborough 2010). It was simply a justification that fit better with a new focus on children's interests and rights, presented as distinct, and thus more likely in conflict with, parental interests and rights.

body to the child's environment, specifically risk factors that are not linked to "actual harm" (Sedlak 2001).The original "harm" standard was defined by a series of categories of physical, sexual, and emotional abuse, as well as multiple forms of physical, emotional, and educational neglect. The new "endangerment" standard broadened the category of maltreatment to include non-primary caretakers, and to include "general or unspecified neglect" and "other or unspecified treatment," A history of the survey explained that the new standard:

> "did not require actual harm to count the child, but allowed cases to be countable if the child was thought to have been seriously endangered by maltreatment or when the child's maltreatment had been substantiated or indicated by CPS" (Sedlak 2001: 46).

The last phrase—"when the child's maltreatment had been substantiated or indicated by CPS"[88]—may appear vague because such substantiation or indication does not overlap with any of the many forms of "actual harm" of the harm standard, including forms of neglect. In fact, this change was a response to what turned out to be the majority of child maltreatment cases: cases of unspecified neglect that did not fall under the NIS definitions of harm (Sedlak 2001: 36). While the number of substantiated "harm standard" reports doubled from an estimated 200,000 to an estimated 400,000 from NIS I to NIS 2, the number of cases rose to 732,000 once the "endangerment standard" was included, with poor families significantly overrepresented among them (NIS 1988: 5.28, 6.3). Yet a majority of the rapidly rising number of child abuse reports and investigations from the 1970s to the 1990s concerned neglect,[89] where poor families were particularly overrepresented (Besharov 2000: 19). This analysis of the NIS changes reinforces the main claim of this chapter: building on an expanded infrastructure (i.e. growing resources for child removal) and a narrowed jurisdiction, a focus on risk funneled multiple issues into the category of maltreatment, defying carefully crafted and clear standards for abuse and neglect.

This trend toward increasing conceptions of maltreatment—and by extension, surveillance and interventions—was also evident in new and expanding categories of maltreatment in the 1980s and 1990s. Sexual abuse reports grew rapidly in the 1980s, attracting significant attention, before declining again in the 1990s (NCPCA 1986-1996); concern over lack of medical treatment—medical neglect—for disabled newborn children dominated child welfare concerns in the mid-1980s;[90] "abandonment" and "lack of supervision" became a significant area of discussion by the 1980s and early 1990s.[91] Some legal scholars began pushing

---

[88] CPS refers to child welfare in this context. See note 44 in Chapter 3.

[89] For data on neglect cases during this period see the "Annual Fifty-State Survey," put out annually from 1986-2000 by the Center on Child Abuse Prevention Research, a program of the National Committee to Prevent Child Abuse, in Denver Colorado. See also the "National Analysis of Official Child Abuse and Neglect Reporting, 1977," published jointly in 1979 by the American Humane Association, Children's Division and the U.S. Department of Health, Education, and Welfare, Office of Human Development Services, Administration for Children, Youth and Families, Children's Bureau, National Center on Child Abuse and Neglect. (DHEW Publication No. (OHDS) 79-30232).

[90] Archival research in the National Archives and Records Administration (College Park, MD) reveals multiple letters addressed to the secretary of the Department of Health and Human Services in 1982 about "baby doe," a case in which a severely disabled infant was allowed to die shortly after birth, with parental consent. Federal regulations were passed by 1983 to in an effort to prevent such cases. See "Note to the secretary," October 25, 1982, and letters to Sen. Strom Thurmond (n.d.) and Congressman Henry Hyde, May 26, 1988, located in the National Archives and Records Administration, RG 468, Department of Health and Human Services, Official Correspondence Files, Box 3, 1982.

[91] See the 1992 and 1993 "Annual Fifty State Survey" reports from the National Center on the Prevention of Child Abuse Research, a program of the National Committee to Prevent Child Abuse (NCPCA) for discussion of these

for child protective intervention in cases of domestic violence (McKay 1994; Tomkins et al. 1992), specifically out of concerns for future risk to the child—risk of physical abuse by either parent, or of psychological scarring from witnessing abuse of a parent. This in turn has led to cases of women losing custody after they reported partner abuse (Schwartz 2020), and in some cases going to prison for "failure to protect" their children from an abusive partner (Murray and Luker 2014; Ortiz 2019).[92] And finally, drug use was increasingly framed not as a health issue, but as a risk factor, one that attracted growing attention in the 1980s. All of these new areas of concern signaled new spaces for child welfare jurisdiction, assessment, and data collection.

Conclusion

This chapter establishes how child welfare became a risk-focused system, in which social work practices emphasized not harm to the child, or "manifest markers" of such, but the environment of the child, or risk factors. In such a paradigm, parental intention is less important than actions, even if those actions are linked to structural inequalities, precisely because those structural inequalities are translated into risk factors. The result of this is that poverty, parental and child age, health crises such as drug use, and other environmental factors are funneled through a narrow focus on child welfare as child maltreatment prevention, a risk-focused framing that disproportionately impacts poor and crisis-ridden families.

Ultimately, a focus on finding ways to effectively respond to skyrocketing numbers of new child welfare cases in the 1970s and 1980s obscured the ongoing issues with this fundamentally reactive system, in which mandated reporters reported a wide range of potential risk, and child welfare agencies tried to keep up with investigations. Unclear definitions of child maltreatment, a few lone voices argued, led to over-removal of children, potentially exposing them to continued risk of maltreatment in foster care (Pelton 1981; Rindfleisch and Rabb 1984; cf. Lawder, Poulin, and Andrews 1985) Yet such concerns were usually overshadowed by funding realities, which prioritized foster care and child removal, as well as continued system stress from high reporting rates—motivated by broad and vague reporting laws—which required a system response, in context of which risk assessment seemed relatively reasonable. In this way, an infrastructural expansion of child welfare that was specifically oriented toward family separation converged with risk assessment as a mechanism for responding to skyrocketing caseloads, (which were themselves the result of an infrastructural factor—the expansion of child welfare's capacity to find these cases through a multi-disciplinary network of mandated reporters). The result was a reinforcement of the funnel effect of child welfare's jurisdictional contraction to child maltreatment, which now included an ever-widening population of at-risk children and their families.

By the 1990s, risk assessment was a fundamental element of child welfare responses. As Reich writes in her ethnography of child welfare (conducted in the late 1990s), "CPS is a system that seeks to rehabilitate or resocialize parents so they can address those aspects of their familial life that appear to place children at risk and then adequately care for their children" (Reich 2005: 5). As Reich notes, the families in her study are overwhelmingly poor, and conditions in their

---

topics. See also the National Center for Child Abuse and Neglect (NCCAN) conference reports for discussions ("Seventh National Conference on Child Abuse and Neglect," 1985, p. 59; "Research Symposium on Child Neglect," 1988, pp. B-2 to B-6; "National Conference on Child Abuse and Neglect," 1993, p. 59).

[92] As in many practice areas related to child welfare, the only rule is that there is no consistent rule; many mothers suffering domestic violence have not experienced child welfare interventions, while others live in fear of it (Sweet 2019).

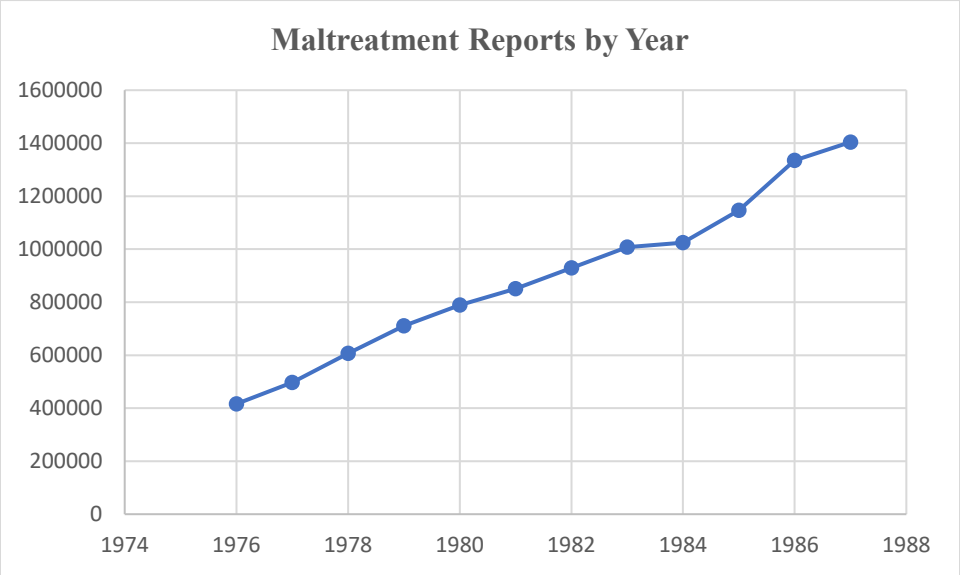
homes were usually not much worse than those in her own middle-class household. Yet, as Reich's language makes explicit, child welfare by the late 1990s was a system that focused primarily on risk assessment and prevention, greatly widening its capacity and jurisdiction for surveillance.

As we transition to our next chapter, we will focus on the 1980s and early 1990s, a transitional era in which the tools for assessing families focused increasingly on risk, and where resources of child removal were significantly higher than for preservation. In this context, understanding this developing and powerful paradigm of risk reduction, in context of a widening multi-professional network of mandated reporters, helps explain how child welfare grew involved in an increasingly broad surveillance of parental behavior, eventually extending to perinatal interventions.

Table 3: Maltreatment Reports, 1976-1987

Year	Reports
1976	416,033
1977	496,483
1978	606,997
1979	711,142
1980	789,071
1981	850,980
1982	929,310
1983	1,007,658
1984	1,024,178
1985	1,146,022
1986	1,334,734
1987	1,404,243

Figure 9: Maltreatment Reports, 1976-1987



Data for Table 3 and Figure 9 from American Humane Association, "Child Neglect and Abuse Reporting," (1976-1987).

CHAPTER 5. SUBSTANCE-EXPOSED INFANTS: A PARADIGMATIC CASE OF RISK

Introduction

A focus on risk assessment transformed child welfare into a system that viewed maltreatment through the prism of risk. An expanded infrastructural capacity, aided by growing funds for foster care and adoption, converged with risk assessment instruments, mandated reporting, and broadening definitions of child welfare to funnel a growing number of issues into child welfare's jurisdiction. This chapter explains how this funnel effect was extended to perinatal regulation in the late 1980s and the 1990s, when a focus on risk enabled a professional framing of a substance-exposed infant (SEI) as the paradigmatic case of a child at risk, requiring surveillance and interventions. Using an analysis of professional discourses related to substance-exposed infants, this chapter establishes how this framing developed, eventually enabling, as documented in Chapter 6, a legislative expansion of child welfare's regulatory interventions in maternal prenatal behaviors.

The story of this chapter begins in the late 1980s. As described in Chapter 4, a risk-focused framing of child welfare governance translated a wide variety of environmental factors into risk metrics, ranging from health and poverty to parental behaviors. Two factors that gained particular interest in the 1980s were drug use and drug use during pregnancy. Risk instruments and social work practitioners increasingly asked about parental drug use, as well as specifically prenatal drug use, as part of the assessment process (Finnegan et al. 1981; Mcdonald and Marks 1991).[93] While pregnancy had long been a site of intervention for social services, increasing concerns about parental drug use meant that substance use and pregnancy converged in the late 1980s into an outsized focus on substance-exposed infants. Most of these cases first emerged in hospital settings, with medical professionals as the front-line respondents. How and why did child welfare become involved in this issue? And how did their response differ from the medical professionals who first encountered these cases? As described in the dissertation introduction, the current literature on prenatal regulation primarily focuses on the criminalization of prenatal substance use, as well as medical interventions, with discussions of child welfare involvement as secondary or as largely conflated with criminalization. Yet by the 1990s, criminalization initiatives had largely failed, and child welfare rapidly became the primary authority sanctioned by state legislatures, bureaucrats, and other professionals to intervene in this issue. This chapter explains the origins of the legitimation of child welfare's regulatory authority over this contentious issue. I show how medical professionals viewed their role as less authoritative, while child welfare professionals built on the profession's ongoing infrastructural expansion and increased protective legitimacy to legitimize further interventions.

This chapter first presents two important contextual findings that explain how child welfare shifted to an authority role in regard to substance-exposed infants. First, the chapter provides a history of pregnancy as a site of surveillance in child welfare, with a specific focus on how this such surveillance incorporated multiple professional fields, especially through the development of risk assessment tools. The chapter then explains the shift to a focus on drug use in particular, which moved from an infrequent topic of professional discussion to the center of an explosion of interest in the 1980s. The goal of this section is to explain how pregnancy and

[93] Note that as late as 1995, some critics still argued that child welfare assessment procedures did not ask enough about parental substance use, or did not sufficiently guide social workers on how to deal with it (Dore, Doris, and Wright 1995).

substance use converged into an area of intervention and regulation by medical and social work professionals, especially social workers in child welfare agencies.

The chapter then proceeds to the main findings of the chapter: an analysis of medical and social work or child welfare journal articles (1978-2000) focused on the issue of substance-exposed infants. The findings of this analysis show two different paradigms of risk in each field, which are linked, in turn, to two different and distinct paradigms of authority. These different paradigms of authority, and their implications for families, are rooted in the professionalization of child welfare and its expanding jurisdiction. The main claim that these findings support is that child welfare interventions were framed as relatively supportive, but they were in fact predicated on the coercive power of child removal. This coercive power was justified, in part, by claims that drug use during pregnancy both directly harmed infants and were linked to long term risk of harm in these infants' futures. As I show in the section below, by the early 1990s, studies indicated that the harms of drug use during pregnancy were mixed, with many children unharmed, and that mothers who used substances were not necessarily more likely to harm their children, especially if they received appropriate treatment. Child removal of a newborn could potentially be very traumatic for both child and mother, and the data indicates that it occurred disproportionately to poor mothers and minorities. Despite these complicating factors, the politics and welfare administrative norms of that period converged with the funnel effect of risk surveillance to justify interventions narrowly focused on potential future child maltreatment.

Pregnancy as a Site of Surveillance

Pregnancy has historically been a site of intervention in social services. Before the expansion of public child welfare in the 1950s, private social agencies, many of them religious, dominated social services, and their priorities included a significant interest in pregnancy, especially of unmarried women. Prenatal clinics focusing on maternity care were discussed frequently in the 1920s, as evidenced by their frequent mention in the National Conference on Welfare Proceedings in 1927-1928. In the first half of the twentieth century, social workers sought to treat "problem" women who became pregnant out of wedlock, in the process asserting their unique expertise as part of the social work professionalization process (Kunzel 1995). Because many unmarried women were urged to give up their children for adoption, family and children's agencies were deeply involved in the regulation of pregnancy, childbirth, and the social construction of what was deemed appropriate behavior surrounding these states. As public child welfare agencies gained more jurisdiction over increased numbers of families, private welfare continued to prioritize pregnancy regulation. Indeed, in a comprehensive survey of child welfare services in 1962, "illegitimacy" was considered a significant problem in 35% of private child welfare cases, compared to only 16% in public child welfare cases (Jeter 1963: 18).[94]

By contrast, social work and child welfare discussions of maternal drug use were relatively minimal until the 1980s. Historical materials as far back as the 1830s indicate concerns about mothers giving opiates to their children and about "congenital addiction," but this was a relatively rare topic in medical or social work publications until the middle of the twentieth century. By the late 1950s, some perinatal researchers began expressing concerns that this might be a widespread problem, and by the 1960s, medical articles documented drug withdrawal

[94] A significant problem meant "among the first three problems" for the child receiving child welfare services. Unmarried parents presented as a "primary problem," i.e., the leading issue for child welfare services, in 29% of private child welfare cases and only 7% of public child welfare cases (Jeter 1963: 18).

symptoms in newborn infants. In 1967, Children's Bureau chief Katherine Oettinger advocated removal of kids from drug-addicted parents, and discussed neonatal addiction as a more common problem than previously considered (Campbell 2000: 145, 158-9, 163). With the exception of such sporadic mentions, for the most part prenatal drug use was not a key issue in the larger and ongoing discussion of pregnancy until the 1980s. Most references to pregnancy in the first National Conference on Child Abuse and Neglect (NCCAN) in 1976 revolved around maintaining proper prenatal care, not drug use. A single presentation in the 1977 and 1979 conference, respectively, discussed the issue and resources devoted to substance-exposed infants in places like California (NCCAN 1977, 1978: 301, 1979: 236).

Pregnancy, however, remained a site of risk, viewed as necessitating surveillance, in social work. In the early stages of risk assessment research, preliminary tools were tested specifically on pregnant and postpartum women in hospitals and medical offices, using data collected from the nurses and doctors who treated them. Researchers explicitly acknowledged that this was partly because they are a relatively accessible group of mothers, since most use hospital and other medical facilities, allowing—with the cooperation of medical professionals—easier access for research purposes. At least some researchers recognized that there were some ethical issues with targeting women for assessment during such a vulnerable period of motherhood (Helfer 1976). Yet this population became a popular target for study, in particular because of the (arguable) assumption that behaviors during the pregnancy and prenatal periods were indicators of later mothering skills. In the 1977 and 1979 National Conference on Child Abuse and Neglect, an annual conference that began in 1976, several studies discussed screening pregnant women as a way to assess for "poor parenting skills" (Lauderdale, Anderson, and Cramer 1978: 81) or to prevent abuse or neglect (NCCAN 1979: 199). Gray et al. published multiple articles based on studies of this population of women, arguing that childbirth and pregnancy is a particularly useful time to predict future parenting (Gray et al. 1976, 1977, 1979).[95] The Gray et al. study surveyed nurses on maternal responses to their newborn infants, their behavior in the labor room, and their attitudes toward their newborn child, as well as interviewing the women.[96] During the 1980s, pregnancy as a site of risk assessment remained a topic of interest for researchers and practitioners developing tools and best practices, some of whom viewed newborn children as vulnerable victims of addicted parents' choices (Finnegan et al. 1981; Kaufman 1991; Royer and Barth 1984).

One important implication of pregnancy as a site of surveillance was that both assessment and interventions were often inherently interdisciplinary, involving both social work and medical professionals. Nurses and doctors were not only mandated reporters, they were the primary source for data on the development of some tools in the 1970s (Gray 1979), and, as described below, these medical professionals remained key actors as the focus of risk assessment shifted to incorporate prenatal drug use in later decades.

Prenatal Drug Use: Constructing a Site of Risk

By the 1980s, drug use both during and after pregnancy began gaining more attention. Parental and prenatal substance use received greater focus in child welfare conferences and

[95] The 1977 and 1979 articles by Gray et al. appear to contain almost identical information, but they were published in different journals and were written in slightly different language.

[96] The authors do not discuss the high levels of stress associated with childbirth and postpartum periods for many mothers, especially those with few resources; the authors also conflate factors related to poverty (not having a telephone was considered a risk factor) with risk for abuse.

surveys in the mid-1980s, continuing well into the 1990s.[97] Yet this was not just an academic research topic. Beginning in the 1980s, state liaisons to the federal government consistently reported to the NCPCA surveys two factors associated with child maltreatment: substance abuse, (especially drugs, but also alcohol) and poverty. In the late 1980s, the limited data available on the topic indicated a rising number of reports related to substance-exposed infants (SEI), including 4,993 SEI reported in New York State in 1989 (Daro and Mitchel 1990: 12). The result of this increased focus was that child welfare services placed a growing number of children, especially infants, in foster care due to drug use; in New York City alone, the number of infants entering foster care, often directly from the hospital, quintupled between 1984-1989 (Haack 1997: 221; USA 1990).

These trends reflected growing attention to drug use in the criminal justice system, as part of the "war on drugs," and the issue attracted significant and sensational coverage in the media. Media coverage tended to moralize prenatal drug use, presenting it as a choice of neglectful and apathetic mothers, and not as a health issue (Campbell 2000; Humphries 1999). This rhetoric reflected larger cultural norms during a deeply racialized period in American media and culture, when strong anti-welfare discourses prevailed and there was either support or indifference toward the costs of the "war on drugs" on African Americans. Pregnant drug users were frequently presented as African American cocaine-addicted mothers of "crack babies" in media, government, and academic sources. The hyper-focus on cocaine in crack form, instead of many other potentially harmful substances—including alcohol, tobacco, and other medical and recreational drugs—was likely linked to its perceived higher use by African American women, who were significantly more likely to be arrested or reported for prenatal drug use, although rates of all drug use was generally equal across all racial groups (Paltrow 2013; Paltrow, Cohen, and Carey 2000). Despite the sensationalistic and empirically dubious basis to this framing, it nonetheless influenced both medical researchers and prosecutors (Gomez 1997). The accompanying images, drawn from archival sources, illuminate the pervasiveness of a framing that both racialized and shamed drug-using mothers during this time. Figure 10 shows a typical article from a national news source, portraying drug use as a choice of African American crack-using mothers; Figure 11 is an article by a respected child welfare researcher, who portrays the drug-using mother as a "threat." Figure 12 is an excerpt from a 1989 report "Perinatal Addiction Research and Education," which was sponsored by the National Association for Prenatal Addiction Research and Education and the Illinois Departments of Alcoholism and Substance Abuse and Children and Family Services. This report, published under the authority of state and national organizations, included a cartoon of a substance-using woman portrayed as both stereotypically African American and as apathetic to the impact of her drug use on her fetus. Figure 13 includes a 1990 DHHS report entitled "Crack Babies," despite the fact that crack use was only a small part of substances that were potentially harmful to children, as well as a 1992 report on "abandoned" boarder babies. These referred to babies whose mothers were deemed unfit to care for them due to drug use, and who may have been compelled to leave them in the hospital; characterizing these children as abandoned was not an accurate portrayal of these cases. These samples of reports and media publications indicate how biased conceptions of substance-exposed infants infiltrated multiple levels of society and governance in this period.

[97] See the "Annual Fifty State Survey" reports from the National Center to Prevent Child Abuse, 1989-1995; see also the report of the National Conference on Child Abuse and Neglect, 1989.

Despite this demonization of drug-using pregnant women, there were no laws passed that directly criminalized prenatal drug use during pregnancy during this period. Some prosecutors were motivated to use other laws, including child abuse statutes, to prosecute such cases (Gomez 1997), but many professionals favored the idea that child welfare or other social or medical services were the best authority for such cases. (There was some variation, as discussed in Chapter 6, with some legislators and professionals supporting criminalization or more intensive forms of surveillance, like civil commitment.) Support for any of these interventions—social services, medical, or criminal—was based on several widespread, yet in fact problematic assumptions: First, that prenatal drug use, especially crack cocaine in the 1980s-1990s, harmed children immediately, causing them addiction and painful withdrawals, as well as harming their long-term intellectual and physical development. Second, that drug use was an activity that people choose to do, not a health problem, and that someone with drug dependency can just "say no." Third, that prenatal drug use indicated a damaged and dysfunctional mother, who was likely to abuse and neglect her children in the long term as well.

By the late 1980s and early 1990s, these assumptions were undermined by medical and social work research. The short- and long-term harm of drugs was highly variable, depending on the amount of use and the specific drugs (Paltrow et al. 2000). By the early 1990s, multiple studies had found that the effects of cocaine in particular were difficult to disentangle from other factors linked to development issues in children (Abrahamson 1998; Skolnick 1990a). This is not to say that drug use cannot or does not harm children, but that other maternal health and behavioral factors, like alcohol or tobacco use, maternal age, or health issues like diabetes, could also potentially harm children. Yet these factors were not moralized, criminalized, or used as a basis for child removal to the same degree as drug use. In particular, the claim that cocaine use had a powerful and negative effect on infants was shown to be fueled by methodologically flawed studies conducted in the mid-1980s (Chasnoff et al. 1985; Lindesmith Center N.D.).[98] More importantly, the assumption that drug use is a choice was consistently rebuffed by medical researchers, who found that addiction is a serious health issue and recommended medically-based drug treatment to address it. Finally, multiple studies from the early 1980s and onward found that prenatal substance use, especially drugs like cocaine, was not necessarily correlated with long-term child maltreatment, and that mothers who had used drugs did not significantly differ from those who did not (Paltrow et al. 2000, see notes 113-116). Some research did link prenatal substance use with later risk of maltreatment (Dore, Joan M. Doris, and Wright 1995b; Jaudes, Ekwo, and Van Voorhis 1995; Kelley 1992; Krugman 1985), but it was difficult to disentangle substance use from other factors, such as lack of prenatal care, poverty, and lack of drug treatment.

Despite these studies and pushback by various advocates for women (Daniels 1996; Gomez 1997), concerns about the harms of a narrow subset of substances to newborns motivated a shift in both focus and practice norms for professionals involved in SEI. In particular, two professional fields were deeply involved in these rising case numbers of SEI in the 1980s and 1990s: medical professionals—such as doctors and nurses who treated pregnant women, and

[98] A 1985 study by Chasnoff et al. was particularly influential in the media coverage of the issue; by the early 1990s, however, Chasnoff, the lead author of the 1985 study, explicitly rejected the idea that cocaine alone was linked to long-term poor outcomes for infants, arguing for a greater focus on poverty as a complex cause of multiple poor child outcomes, including those related to prenatal substance use. See this February 1993 news release from the National Drug Strategy Network: http://www.ndsn.org/FEB93/BABIES.html, accessed June 17, 2021.

social workers who responded to the rising reports of prenatal drug use from medical professionals and other mandated reporters.

Yet while some state legislatures pushed for medically-based treatment of pregnant and postpartum drug users, this appeared to have little effect on the rising numbers of children investigated by child welfare and placed in foster care due to maternal drug use; as previously noted, foster care was an uncapped federal entitlement in this period and so funding for child removal was generally more accessible and plentiful than for other solutions. Indeed, by the late 1980s, the number of infants in child welfare supervision and in foster care were rapidly rising; a 1989 study found that 89% of child welfare cases involving infants in Boston included parental substance use as a factor (Haack 1997: 218, 221). How did social work and child welfare professionals become a dominant authority over cases of SEI, and how did their approach to the issue differ from medical professionals? This is the focus of the findings described in the next section.

Professional Discourses Regarding Substance-Exposed Infants

Emerging public awareness of what was later labeled the first wave of substance-exposed infants,[99] primarily cocaine-exposed newborns, aroused significant discussion in professional journals. When tracked over time, these discussions reflect themes of risk, authority, and justified interventions related to SEI. A central topic in these journals mapped on to broader public discourses: How should women who use potentially dangerous substances during pregnancy be treated? Specifically, what kinds of interventions were required: criminal sanctions, social services, or medical services?

This content analysis of professional discourses moves beyond prior scholarship on perinatal regulation to show how professional discussions and interventions in substance-exposed infants were fundamentally linked to conceptions of pregnancy as a site of risk. To explain this, assisted by a team of undergraduate researchers, I conducted an analysis of professional journal articles (1978-2000) to find articles that use one or more of a set of twelve terms related to substance-exposed infants. These twenty-two years from 1978-2000 were a crucial period in which both child welfare attitudes toward risk evolved, and broader professional practices and policies around SEI developed. I distilled the resulting population of 3450 articles to 123 articles that directly discussed issues related to substance-exposed infants, with the journals categorized into four main disciplines: medicine, social work, public health, and bioethics (see Table 4). Note that I chose social work as well as child welfare journals because child welfare workers and researchers often publish in broader social work journals.

For all of these articles, I used the Complex Text Coding method to analyze them both qualitatively and quantitatively (Lichtenstein and Rucks-Ahidiana 2020). For the purpose of this chapter, I focused on medical and social worker articles (N=75) because those professionals were (and are) the most directly involved with SEI cases (see Table 4). I contextualized this analysis with data from contemporaneous articles on risk assessment and conference and survey data, where relevant. The goal of this analysis was to track common themes related to authority and risk in these discussions, and to simultaneously track issues of class and race. Specifically, I tracked if articles discussed overrepresentation of racial minorities and poor women in their

[99] The first wave, in the 1980s, was largely linked to cocaine use. The 1990s saw a spike in meth-related substance-exposed infants, and the largest spike, beginning in the 2000s, continues to be related to opioid use. Note that these waves are largely constructed and related to media coverage (Gomez 1997; Humphries 1999).

samples, if they discussed race and poverty at all, and if so, how they addressed the issue. Do authors discuss racial and income inequalities and structural challenges to overcoming them, or did they note race and poverty as simply risk factors for maltreatment, without linking them to structural issues or potential systemic solutions? These factors were analyzed alongside questions of whether an article discussed risk of harm as a long-term, indirect factor or short-term direct issue, as well as how authority was conceptualized—what intervention powers did the medical and social worker professional have or claim they should have in their relationships with substance using women? This analysis demonstrates how discussions of substance-exposed infants unfolded primarily in context of discussions of risk of harm (although not necessarily harm itself), but very different ideas of risk were linked to different professional fields. Ultimately, I show that these contrasting conceptions of risk were linked to specific types of authority adopted by medical and social work professionals, which were in turn legitimized by legislative and social norms related to state regulation of families.

Risk and Authority in Medicine and Social Work

Two distinct framings of risk emerge from content analysis of professional journal articles: *Direct* and *indirect* risk, which were linked, respectively, to two different kinds of authority—*consensual* and *coercive*. While researchers and practitioners from both medical and social work fields overwhelmingly dismissed criminalization as a valid option (unlike the fierce debate regarding civil commitment in the bioethics and legal realms, as noted in Chapter 6), they differed on their recommended interventions in ways that reflected their respective professional roles.

Medical Response: Direct Risk and Consensual Authority

Medical article authors focused on *direct risk*, meaning the often causal links between behaviors that actors (i.e. pregnant women) engage in and direct outcomes of these behaviors. These articles seek evidence of the imminent medical outcomes of specific substances (ranging from medical prescriptions to illegal or legal recreational substances) on the pregnant woman and the fetus or newborn. Typical examples of these include articles discussing the direct link between maternal substance use and birth defects or low birthweight of the newborn (Gideon, Anne, and Shinya 1998; Ouellette et al. 1977; Skolnick 1990b). This framing of direct risk was linked to a *consensual authority model*, driven by legal and bioethical mandates to obtain patient consent for treatment. In this spirit, medical articles generally recommended counseling, but not mandating, against specific substance use.

In practice, medical authority can be quite coercive, both due to the power differential in the patient-practitioner relationship, as well as medical involvement in court mandated treatment (Daniels 1996; Paltrow and Flavin 2013). Yet these coercive practices were generally omitted from discussions in medical articles, which focused instead on a counseling approach, in which the doctor bore no responsibility for intervention once women left the office. As one author wrote in a typical representation of recommended responses to substance use during pregnancy: "Physicians should describe to women of childbearing age the potential risks of alcohol to fetal growth and development" (Vega et al. 1993). This framing was linked to an occasional critique of mandated reporting laws and social services responses, as compared to "objective medical criteria" (Chasnoff, Landress, and Barrett 1990). As one medical article noted, "…[mandated] reporting criteria sometimes may be based more on racial and economic biases than on sound medical reasons…" (Skolnick 1990b).

Social Work Response: Indirect Risk

In contrast, social work articles (both in child welfare and general social work journals) focused strongly on *indirect risk*, meaning long-term, loosely correlated outcomes, primarily how prenatal substance use is correlated with maternal behavior later in the child's life, as well possibly long-term outcomes for the child's well-being. Examples of these include issues ranging from long-term physical, mental, and emotional health, to parental abuse and neglect. As seen in Table 5, the majority of social work articles focused on indirect risk, in striking contrast to medical articles. While 93% of medical articles focused on direct risk, 61% of social work articles focused primarily on indirect risk, and an additional 9% (n=3) of social work journal articles focused on both indirect and direct risk (two of those were authored by medical professionals writing for a social work audience).[100]

Following are some examples of articles that were coded for indirect risk. A study of characteristics of substance using women stated that "We hypothesized that maternal demographic and psychosocial factors, measured at birth and characteristics of the neonate, would be predictive of subsequent disruption in care of infants of substance abusing women" (Nair et al. 1997: 1041). Another article noted that "Problems common to drug-dependent women place them at increased risk for inadequate parenting…" (Kelley 1992: 318). Articles like these generally addressed the many mediating characteristics that might also contribute to maltreatment, but the primary relationship the articles studied was the long-term possibility of maltreatment by women who used substances during pregnancy.

SEI as Risk Factor: The Funnel Effect of a Risk Paradigm

Discussions of prenatal substance use were imbedded in a broader child welfare discourse of risk as constituting multiple structural and individual factors. However, child welfare's narrow focus on maltreatment risk meant that while some practitioners did recommend comprehensive and interdisciplinary interventions, in practice, agencies and workers frequently linked prenatal substance use to risk of future abuse or neglect. This approach funneled more complex, structural issues of health, substance dependency, and poverty into a narrow frame of individual parental maltreatment of a child, which had particular implications for historically disadvantaged groups like poor mothers of color (as noted above, the predominant demographics in this group in the 1980s and 1990s were poor and African American). Practically, while resources varied greatly across states, many child welfare agencies had few well-funded tools other than family surveillance and child removal. The administrative and political factors that encouraged this approach demonstrate the continued impact of the jurisdictional contraction of child welfare in the 1960s-1970s, in which the consequent risk-focused paradigm of child protection catalyzed a funnel effect that transformed multiple environmental issues into maltreatment risk factors.

An article from 1996 illustrates the contrast between an aspirational framing of risk as multi-factor and the practical application of risk assessment as a funnel for translating health and economic problems into maltreatment. The article begins with an introduction that notes: "Practitioners and researchers in the field of child welfare have come to embrace an ecological model for assessing risk and well-being in families. Such a model acknowledges the

[100] Note that out of the twenty social work journal articles that focused primarily on indirect risk, nine also discussed direct risks, but generally only as a brief mention. The primary focus was on indirect, long-term risks. In contrast, only four of the 39 medical journal articles that focused on direct risk also mentioned indirect risks. This is probably because social work articles could bolster their case for interventions by also noting direct risks. Medical journal articles, however, generally were not focused on long-term risks as part of their studies.

multicausality of risk, that is, that child abuse and neglect are most often the result of a number of risk factors, not just one. Commonly identified risk factors include social isolation, poor parenting skills, and high levels of family stress.... Parental substance abuse is an important potential risk factor…"

Yet just a few paragraphs later, the author noted that, in practice, "child placement and reunification decisions are all too often based on the number of "clean" or "dirty" urine screens reported for a given parent rather than a comprehensive assessment of risk factors, strengths, and supports available for the care and nurturing of children" (Azzi-Lessing and Olsen 1996). That is, despite the aspirations to address the multiple issues and family needs in cases of drug use, understood as a risk for child maltreatment, child welfare workers remove (and reunify) children on the basis of the parents' success at remaining drug-free—without necessarily accounting for or providing resources to help them do so.

Faced with broad aspirations for supporting families coupled with minimal resources and mixed and evolving responses to the issue of SEI, social work articles presented drug-using pregnant women and mothers in two contradictory ways, sometimes simultaneously. In one framing, women who used substances deemed harmful to their fetus and future child were presented by some social workers as pathological. For example, researchers studying such mothers in the late 1980s argued that "Mothers who give birth to infants while abusing drugs tend to be immature women who demonstrate an abnormal degree of egocentrism in the way they go about parenting" (Burns & Burns 1988). Such negative framings were linked to broad cross-disciplinary debates in which some professionals and academics argued that only punitive responses, such as civil commitment, a ban on breastfeeding, or other court-sanctioned responses, were appropriate in such cases (Bross 1979; Kaufman et al.1986; Mathieu et al. 1996). Yet others also argued that women in these situations require comprehensive services, views that would appear sporadically in articles throughout the 1980s and 1990s. For example, one article noted that: "A primary goal of social work practice with pregnant women is to improve the outcome of pregnancy and thereby prevent fetal and infant damage, disease, and death" (Royer & Barth 1984). Pushing back against calls for punitive action in the 1990s, another article argued that: "To effectively serve chemically dependent women, experts have called for nothing less than a paradigm shift that would refocus services on the needs of the family and on the broader social and economic needs of women in treatment" (Azzi-Lessing & Olsen 1996). Of course, as this dissertation indicates, this was less a paradigm shift and more a reversion to a historical paradigm of rehabilitative and comprehensive services for children and their families.

Translating Structural Inequality into Risk

While some social work researchers and practitioners were aware of the structural inequalities imbedded in their investigations of SEI, they were not necessarily provided or even trained to respond to these inequalities effectively, whether by providing resources for long-term, effective drug treatment, support for financial needs, or sensitivity toward racial inequalities that led to overrepresentation of minorities in child welfare. In the 1980s and 1990s, this was particularly apparent in deeply racialized framings of the issue of substance-exposed infants. Sixty seven percent of social work articles (and 9% of medical articles) focusing on SEI discussed race, and articles in both medical and social work journals discussing surveys of such women make clear that these women are overwhelmingly minorities—usually African American—and poor (Jaudes et al. 1995; Kelley 1992; Marcenko and Spence 1995; Starr 1978;

Vega et al. 1993). Yet while the calls for holistic responses noted above indicate at least limited recognition of these structural inequalities, the article authors often note these disproportionate demographics descriptively, without acknowledging racially disproportionate outcome.[101] There are exceptions to this in social work journals (Carten 1996); one author argued against the demonization of poor women of color in particular, noting that "groups already vulnerable because of variables such as income levels or race appear to be at an elevated risk of being labeled the enemy" (Gustavsson 1991: 277).

A framing that described minority women as "crack moms" was affirmed by widespread media coverage and state and national research organizations' publications, which tended to racialize drug users without questioning these assumptions (see Figures 10-13, described above). Indeed, studies from that time indicated that minority women were likely over-tested due to stronger testing policies and weaker legal protections in public hospitals that served them, and they were thus more likely to fall under the surveillance of child welfare (Adirim and Gupta 1991). Such women's marginalized status in American society could also be framed as linked to pathological issues in some publications, presenting them as higher risk for substance use. As one researcher argued: "Crack also heightens, if only temporarily, the user's sense of personal power and control, feelings not often experienced by women, especially poor and minority women" (Dore et al. 1995: 533).

These poor and minority women constituted the majority of cases in which social workers intervened. Social work interventions in such cases were linked deeply to conceptions of risk that were predicated on the poor conditions of these women's lives—whether health issues, poverty, or social marginalization that they suffered due to racial and income inequalities– but social work assessments usually decoupled risk of maltreatment from those conditions. Instead, the articles indicate that social work practices presented prenatal substance use as a paradigmatic example of indirect risk, or risk to the child's future, which justified increased surveillance as narrowly linked to the risks prenatal substance use present for the child's future well-being. The language of the quotes below, from a sampling of these articles, use terms that are proxies for risk—"possibilities," "environment," and "potential"—in a multi-decade argument that risk requires surveillance and intervention.

Examples of this link between environmental, indirect risks and substance use include an article that noted concerns about the "possibilities of abuse by the parents, either as a consequence of disturbed maternal bonding or of the difficulties experienced in caring for these infants as neonates" (Starr 1978). Another article focused on environmental factors, illustrating how a risk paradigm encouraged a focus on the child—and their parent's—environment, not simply harm to children's bodies: "While drug dependence does not preclude good parenting, the violent and unstable environment in which the drug dependent woman often finds herself may contribute toward a high risk of child neglect with the potential for abuse" (Finnegan et al. 1981). In the majority of child welfare articles, these risks were linked with recommendations for comprehensive services, oriented toward family reunification, a form of gentler but pervasive surveillance (Azzi-Lessing and Olsen 1996; Carten 1996; Sagatun-Edwards, Saylor, and Shifflett 1995). Yet in practice, as authors noted, these comprehensive services were often unavailable, and state welfare administrators were not always convinced they were helpful. As one USDHHS report stated:

[101] This is also (and especially) true in medical articles reviewed for this chapter, although those are not usually linked to coercive interventions.

> Current child welfare laws were written under the assumption that virtually all families were redeemable. Many experts dealing with crack addicted parents, however, are now wondering if that assumption is valid. The current population of cocaine exposed children and crack families did not exist in 1980 when the foster care system was last revised, and it may be that the system does not suit the needs of this new generation of children (Feig 1990).

In this broader administrative context, child welfare's focus on the long-term, indirect risks of harm justified surveillance not for supportive services, but for coercive interventions. The next section illustrates the shift toward such justifications.

Linking Indirect Risk to Coercive Authority

Justifying surveillance by pointing at potential risks to children's well-being was linked to a *coercive authority model*, in contrast to the medical articles' professed consensual model. A larger debate around this issue unfolded between bioethicists and lawyers, who debated whether or not substance-using women should be civilly and involuntarily committed (Abel 1998; Chavkin 1996; Mathieu 1995; Peretz and Schroedel 1996). Such drastic measures were rare in social work and child welfare journals, though one article in *Child Abuse and Neglect* argued that fetuses in the third trimester should be considered covered by dependency statutes (i.e., considered the equivalent of a child); as a result, the author suggested, the ingestion of some dangerous drugs might qualify as child abuse, and the woman should perhaps be "reported to a restraining order against breast feeding" (Kaufman et al. 1986). Yet these statements were rare, a rarity partially due to a lack of explicit recognition of the coercive power that underlay interventions by child welfare workers. One article in the 1990s, however, made this link explicit:

> Indeed, there is evidence that motherhood can sometimes be the needed impetus for sobriety for substance abusing women.... However, …the road to sobriety is often perilous and requires constant encouragement and support. Because of the social isolation… a child welfare caseworker may be the only consistent resource available for this support. In addition, the legal sanctions adhering to child protective investigations give child welfare caseworkers unique access to these closed family systems, as well as singular leverage to pry caregivers into assessment and treatment (Dore et al. 1995).

That is, child welfare agency employees are not simply focused on assessing risk. They are also effective at surveilling risk because they can coerce maternal behavior through "legal sanctions"—i.e., the threat of child removal and other interventions, some presented as supportive, but all undergirded by arousing the mother's fear of losing her child. Few articles explicitly stated this. Yet as much as at least some child welfare practitioners may have intended a more holistic approach to prenatal substance abuse, their authority for any interventions rested on their unique power to separate parents and children, a power that other professionals did not wield. This power was enforced by funding structures in child welfare: because most federal funds are explicitly mandated only for children in out of home care (SSA Title IV-E), more effective solutions like mother-child co-resident drug treatment were not an option child welfare could provide in most cases; (this is usually the case today as well). Instead, separation was the main mechanism for intervention. As the next chapter shows, child welfare's mix of coercive power and protective authority enabled policymakers to situate child welfare—sometimes unwillingly—as a legitimate regulator of substance-exposed infants and their mothers.

Conclusion

This chapter has focused primarily on how conceptions of risk became central to child welfare governance, which, when converging with expanding reporting requirements and professional cross-system interventions, enabled increasing surveillance and interventions in American families. I also show how these broadened conceptions of risk were key to the social workers' understanding of their role in cases of prenatal substance use. Specifically, this chapter demonstrates how pervasive risk assessment and reduction discourses framed the substance-exposed infant as a paradigmatic case of a child who was not necessarily harmed, but seen as "at risk" for future harm, justifying surveillance and interventions.

This framing of SEI has two significant implications for American child welfare and the regulation of American families: First, this focus on SEI once again expanded the parameters of child welfare jurisdiction through a funnel effect of a narrowly risk-focused paradigm of child maltreatment. Child welfare was still narrowly focused on maltreatment, but a risk paradigm, in which all risk factors must be assessed for concerns about potential future maltreatment, meant that an increasing number of issues fell under this contracted jurisdiction of child welfare. Moving beyond poverty, health issues like drug dependency, especially during pregnancy, were now considered important risk factors that justified interventions. This funnel effect converged with another crucial factor: the availability of an expanded infrastructure of a widespread child welfare system, supported by a network of mandated reporters and growing funds for child removal, to engage in these interventions.

The integration of SEI into child welfare jurisdiction is also evident in the broader process of child welfare professionalization, in which researchers, influenced by practitioner norms, negotiated and refined conceptions of neglect and abuse. This process of defining and refining definitions was ongoing in the 1980s, (as noted in Chapter 4). By the end of the decade, prenatal exposure was seen as a sub-category of neglect, or "prenatal neglect," by at least some child welfare experts (NCCAN 1988: 7, 55). A review of child welfare surveys shows that in later years, the issue seemed to slip between categorizations of neglect, endangerment, and abuse, although the latter was generally only warranted if the infant showed symptoms of exposure. An illuminating reflection of this slow incorporation of perinatal protection into the purview of child welfare authorities emerges in the studies conducted by the National Incidence Studies (NIS) and in the National Child Abuse and Neglect Data System (NCANDS) data collection efforts. The codebooks to NIS barely note the issue of prenatal exposure in the 1981 and 1986 publications, then offer a justification in 1996 for why they track it even if it isn't an official category of abuse in the survey, and then finally omit justifications and simply present detailed coverage of the issue by 2010. The federally mandated and sponsored NCANDS, which began collecting state level maltreatment data in 1990, at the height of child welfare concerns (and media coverage) about drug-exposed infants, included a new category of child maltreatment victim in their surveys, one that did not exist in any prior studies on child abuse: the "unborn child." It is important to note that NCANDS was largely a collection system for state reports of maltreatment. A new category signified a new population of child welfare surveillance, both in practice—reflecting reports that NCANDS was collecting from state agencies—as well as in a state-sanctioned system of recognition of child welfare jurisdiction, in which this category was made visible to policymakers, researchers, and practitioners.[102]

[102] Note that while data on "unborn children" was available to researchers in NCANDS dataset, the data was not published for the general public in the Children's Bureau's annual "Child Maltreatment" reports until 2018, due to issues with data quality.

A second important implication of this risk-based framing of SEI regulation unfolded in the practices of child welfare agencies. The integration of SEI as a risk factor for maltreatment and the gradual, albeit halting, legitimation of child welfare authority over this issue, had important practical implications for families. The rising numbers of children entering foster care were attributed at least in part to parental drug use, with an overwhelming percentage of infants attributed to substance use (Haack 1997). In one study of a California district in 1989-1990, out of 284 cases of newborns suspected of exposure to prenatal substance use by their mothers–who were disproportionately single, unemployed, African American or Hispanic, with two-thirds of them cocaine users—65% (186) were immediately removed, with 24% (69) permanently removed (Sagatun-Edwards et al. 1995). These were deeply invasive outcomes with potentially profound trauma for families, yet the evidence that such removals were justified was limited at the time. These trends accelerated over time, and even as more evidence emerged that child removal was not supported as in the best interests of the child –and was opposed by some medical practitioners –their authority was legally outweighed by social worker decisions, which carried with them the power of child removal.

This analysis provides the necessary background to the next chapter, which demonstrates how child welfare's distinctive brand of authority—a mix of supportive and coercive regulatory powers, reinforced by an expanded infrastructural capacity for intervention—became increasingly viewed as a useful alternative to criminalization in cases of prenatal substance use. Child welfare's pre-existing jurisdictional legitimacy in turn legitimized an expansion of their regulatory authority over substance-exposed infants and their mothers. This shift in perspective was crucial to the policy developments that still shape child welfare practices and norms today.

Figure 10: Media on Prenatal Drug Use

For Pregnant Addict, Crack Comes First

Drug Use Blamed for D.C. Infant Deaths

By Lynne Duke
Washington Post Staff Writer

Renay Shipman calls her circle of dope-smoking friends the "beam team." Together they beam up on crack.

The team has an unseen, silent member who has no choice but to go along—a fetus, due in January, who squirms and fidgets whenever Shipman inhales the vapors of a rock crackling in her pipe.

"Sometimes when I hit and it don't move, I be, like, 'Oh, my God,' " Shipman said.

"I think I shouldn't do it, but I be saying, 'You'll be all right,' " she said, patting her stomach.

It is a lie and she knows it.

The truth is more painful, more confusing. Shipman, 25, can't quite explain it. Crack is "a want, it's a need," she said. She doesn't mean for the cocaine to harm the fetus.

"It might be addicted," she conceded. "I don't want it to die."

But crack comes first.

"I ain't stopped smoking since I found out I was pregnant," Shipman said impassively while lying on a bed in a Congress Heights apartment Wednesday. "I smoked the whole time. Toward the end, it's increasing .... It's gotten to be every other day now."

No one knows how many Renay Shipmans are out there. But District doctors and public health officials say they increasingly are seeing what these women have wrought: tiny babies, sickly babies, deformed babies, dead babies.

Indeed, they say that crack use by pregnant women is the root cause of a steep rise since January 1988 in the number of babies dying in the city. In 1987, 199 babies died. Last year, 244 died. In the first half of this year, 131 died.

It is bad enough that any baby dies. What's worse, doctors say, is that most of the deaths in the District are preventable, always have been. If only pregnant women would take better care of their health, eat proper foods, stop smoking cigarettes, stop drinking alcohol, stop risking venereal disease, then the city's rate of infant deaths would go down.

For a few years in the middle of the decade, it appeared there was hope. More women went to prenatal clinics. Fewer babies died. Outreach and education campaigns appeared to be working.

See ADDICT, A10, Col. 1

BY JOHN McDONNELL—THE WASHINGTON POST

Renay Shipman, with her younger child, fears her unborn baby is addicted.

Washington Post, December 18, 1989

Figure 11: "Crack babies"

Crack Babies: The Worst Threat Is Mom Herself

By Douglas J. Besharov

LAST WEEK in this city, Greater Southeast Community Hospital released a 7-week-old baby to her homeless, drug-addicted mother even though the child was at severe risk of pulmonary arrest. The hospital's explanation: "Because [the mother] demanded that the baby be released."

The hospital provided the mother with an apnea monitor to warn her if the baby stopped breathing while asleep, and trained her in CPR. But on the very first night, the mother went out drinking and left the child at a friend's house—without the monitor. Within seven hours, the baby was dead. Like Dooney Waters, the 6-year-old living in his mother's drug den, whose shocking story was reported in The Washington Post last week, this child was all but abandoned by the authorities.

Why aren't we protecting these children? One major reason is that, paradoxically, we continue to entrust their care to the very parents who are threatening their well-being. Instead of tackling head-on the tenet of prevailing social welfare policy that holds that children are almost always better off with their mothers, discussion has focused on options for dealing with the drug-addicted mothers: whether to concentrate on drug-treatment services or prosecution. These are important concerns, but they do not go to the heart of what must be done—now—to protect these children.

DAVID DIAZ FOR THE WASHINGTON POST

The first thing to understand in this debate is that crack is uniquely dangerous. Other drugs have plagued our society since the 1960s, but cocaine, and especially its derivative, crack, poses a threat to many more young children—because mothers use it. According to Dr. David Bateman, director of perinatology at New York's Harlem Hospital, "Heroin was a man's drug and we just didn't see as much of it in pregnant women. Many more women are on crack than ever were on heroin."

Almost 20 years ago, as director of the New York State Assembly Select Committee on Child Abuse, I studied heroin-withdrawal babies in New York City. Nothing I learned then prepared me for the devastating damage cocaine is doing to children.

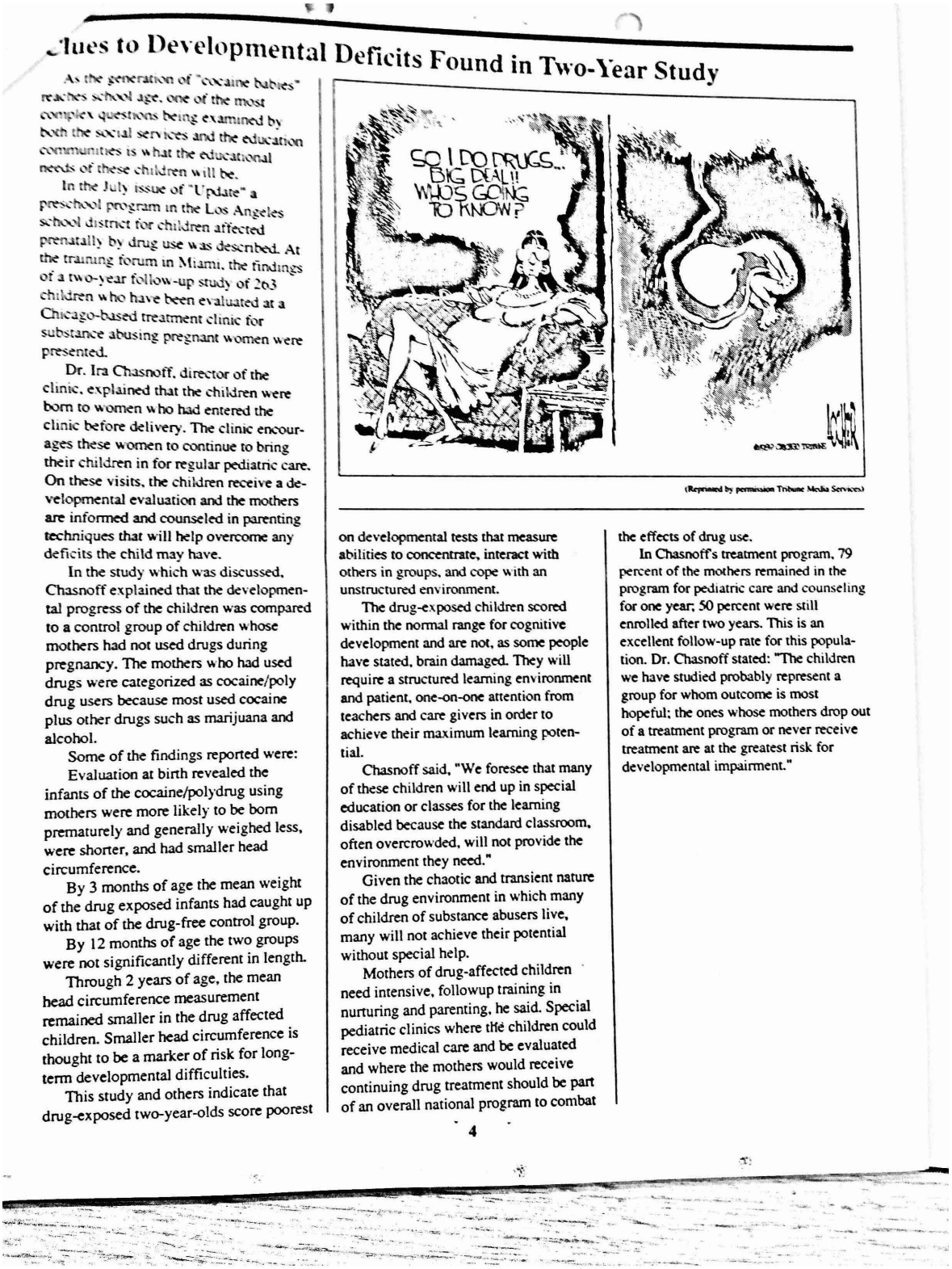
Cocaine is very harmful to the fetus. Some infants are born with deformed hearts, lungs, digestive systems or limbs; others suffer what amounts to a disabling stroke while in the womb. The problem isn't of intractable proportions: The most widely cited estimate—up to 375,000 fetally exposed babies (or "crack-babies") born per year—is much too high. A more

See CRACK, B4, Col. 1

Douglas Besharov, resident scholar at the American Enterprise Institute, was the first director of the National Center on Child Abuse and Neglect. His book, "Recognizing Child Abuse and Neglect," will be published by the Free Press this winter.

Washington Post, August 6, 1989.

Figure 12: Racialization of Prenatal Substance Use



Clues to Developmental Deficits Found in Two-Year Study

As the generation of "cocaine babies" reaches school age, one of the most complex questions being examined by both the social services and the education communities is what the educational needs of these children will be.

In the July issue of "Update" a preschool program in the Los Angeles school district for children affected prenatally by drug use was described. At the training forum in Miami, the findings of a two-year follow-up study of 263 children who have been evaluated at a Chicago-based treatment clinic for substance abusing pregnant women were presented.

Dr. Ira Chasnoff, director of the clinic, explained that the children were born to women who had entered the clinic before delivery. The clinic encourages these women to continue to bring their children in for regular pediatric care. On these visits, the children receive a developmental evaluation and the mothers are informed and counseled in parenting techniques that will help overcome any deficits the child may have.

In the study which was discussed, Chasnoff explained that the developmental progress of the children was compared to a control group of children whose mothers had not used drugs during pregnancy. The mothers who had used drugs were categorized as cocaine/poly drug users because most used cocaine plus other drugs such as marijuana and alcohol.

Some of the findings reported were:

Evaluation at birth revealed the infants of the cocaine/polydrug using mothers were more likely to be born prematurely and generally weighed less, were shorter, and had smaller head circumference.

By 3 months of age the mean weight of the drug exposed infants had caught up with that of the drug-free control group.

By 12 months of age the two groups were not significantly different in length.

Through 2 years of age, the mean head circumference measurement remained smaller in the drug affected children. Smaller head circumference is thought to be a marker of risk for long-term developmental difficulties.

This study and others indicate that drug-exposed two-year-olds score poorest on developmental tests that measure abilities to concentrate, interact with others in groups, and cope with an unstructured environment.

The drug-exposed children scored within the normal range for cognitive development and are not, as some people have stated, brain damaged. They will require a structured learning environment and patient, one-on-one attention from teachers and care givers in order to achieve their maximum learning potential.

Chasnoff said, "We foresee that many of these children will end up in special education or classes for the learning disabled because the standard classroom, often overcrowded, will not provide the environment they need."

Given the chaotic and transient nature of the drug environment in which many of children of substance abusers live, many will not achieve their potential without special help.

Mothers of drug-affected children need intensive, followup training in nurturing and parenting, he said. Special pediatric clinics where the children could receive medical care and be evaluated and where the mothers would receive continuing drug treatment should be part of an overall national program to combat the effects of drug use.

In Chasnoff's treatment program, 79 percent of the mothers remained in the program for pediatric care and counseling for one year; 50 percent were still enrolled after two years. This is an excellent follow-up rate for this population. Dr. Chasnoff stated: "The children we have studied probably represent a group for whom outcome is most hopeful; the ones whose mothers drop out of a treatment program or never receive treatment are at the greatest risk for developmental impairment."

(Reprinted by permission Tribune Media Services)

4

Figure 13: State Actors on Prenatal Substance Use

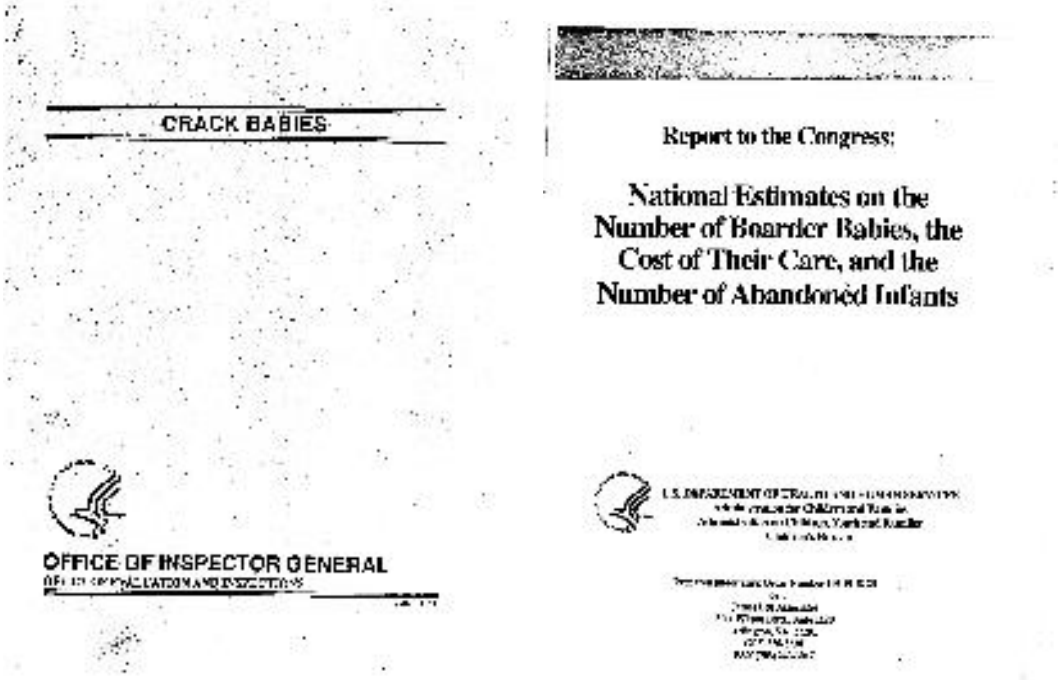


Table 4: Articles selected for analysis of SEI discourses

Jurisdiction	**Articles**
Medical	42
Public Health	25
Social Work	33
Bioethics/legal	23
Total:	123

Table 5: Social work and Medicine – Direct versus Indirect Risk

Jurisdiction-Risk	Direct Risk	Indirect Risk	Mixed	N/A
Medical	93%	7%	0%	0%
Social Work	18%	61%	9%	12%

CHAPTER 6. CHILD WELFARE AND PERINATAL REGULATION

Introduction

The preceding chapters have established that an infrastructurally expanded and jurisdictionally contracted field of child welfare developed a "funnel effect" mechanism, which intensified jurisdiction over an increasing number of family regulatory interventions through a focus on risk. A risk-focused paradigm funneled multiple issues into a narrowly construed regulatory jurisdiction of maltreatment prevention. This chapter focuses on an increasingly significant outcome of this process: the reframing of substance-exposed infants as a paradigmatic example of a child at risk. How did this happen and how did it impact mothers and families? In this last empirical chapter of my dissertation, I argue as follows: A framing of child welfare authority as a mix of coercive surveillance and protective support, supported by a nationwide infrastructure staffed for interventions, legitimated bipartisan legislative efforts to expand child welfare authority over substance-exposed infants and their mothers. These policies remain in place as the dominant form of perinatal regulation until this day.

This stage represents the second juncture in which infrastructural expansion and pre-existing jurisdiction help legitimate further expansion of child welfare regulatory authority.[103] By the late 1980s, child welfare funding was rising steadily, albeit mostly for the purposes of family separations, funding a sprawling infrastructural capacity in which child welfare workers were widely available across most regions of the United States. This infrastructure was reinforced by two decades of mandated reporting across multiple professions, a massive industry of research on child maltreatment and on risk assessment tools, and professional development trends that had established child welfare as the primary regulator of American parenting norms.

In this context, growing public and media attention to substance-exposed infant translated into growing awareness of this problem in the halls of state legislators. There were four ways in which state legislators could respond to this issue: the first was criminalization, in which mothers and pregnant women could be held criminally liable for drug use during pregnancy. The other three were all forms of civil regulation: child welfare interventions, medical interventions, and finally, civil commitment, which means keeping a pregnant woman in a non-jail restrictive setting so she cannot access substances.

Yet due to the institutionalization of child welfare as a protective authority, reinforced by mandated reporting laws and widespread infrastructural capacity, a rising number of prenatal substance exposure cases were de facto reported to child welfare agencies, even if other authorities were also involved (Daro and Mitchel 1989, 1990; USA 1990: 30). Yet the predominance of child welfare regulation of substance-exposed infants is mostly overlooked by the existing literature on perinatal regulation. Scholarship from the 1990s to this day tends to focus on the criminalization of pregnancy—often conflating civil and criminal regulation and linking interventions in substance-exposed infants to anti-abortion advocacy, medical professional authority, or a racialized war on poverty and drugs (Gomez 1997; Paltrow and Flavin 2013; Roberts 1997; Solinger 1998). However, as this chapter demonstrates, criminal and medical interventions are far less frequent, systematic, and institutionalized than child welfare interventions in the issue of substance-exposed infants. The findings described in the chapter show that by isolating fetal protectionism from child protectionism, the existing narrative misses

[103] The first was the expansion of child welfare's jurisdiction over child maltreatment, which led to a jurisdictional contraction that excluded most other child welfare issues (see Chapter 3).

the broader institutional development—both infrastructurally and jurisdictionally—of child welfare, in which agencies expanded interventions into a wide range of family issues. This chapter illuminates how broader trends in American governance enabled an expansion of specifically civil regulation, in the form of state laws that primarily authorized child welfare. Such policies usually authorized child welfare to engage in direct interventions, but they were also heavily involved in civil commitment procedures. Criminalization, however, largely failed, with no states passing laws criminalizing women during the 1978-2014 period, and only sporadic and frequently overturned prosecutions, usually taking place on the basis of other laws.

To explain the rise of child welfare authority over this issue, this chapter provides a legislative history of American perinatal regulation, anchored by two case studies of state policy development. After establishing the failure of criminalization as state policy in nearly all American states, I describe the broader rise of civil regulation of pregnancy. I first provide an explanation of civil regulation in the United States, followed by an overview of the civil regulation of pregnancy in particular—from financial disputes to a multitude of fetal harms. Finally, I discuss the rise of state-level regulations of substance-exposed infants, generally using civil regulatory procedures. The first and most predominant type of civil intervention in cases of substance-exposed infants, beginning in the 1980s and continuing to the present, is child welfare; the second and less predominant, which involves child welfare as one of several authorities, is civil commitment. To explain how these two different policies unfolded, I present case studies of both forms of state legislative development: California, selected to represent liberal legislators' authorization of child welfare interventions as the primary form of perinatal regulations, and Wisconsin, selected to represent the less common but still significant path of civil commitment, implemented by a Republican dominated legislature. Both of these cases illuminate the failure of criminalization and how an expanded infrastructure and risk-focused jurisdictional legitimacy enabled child welfare-dominated civil regulatory policies.

Legislative Context: The Failure of Criminalization

As reports of substance-exposed infants to child welfare rose, media coverage increasingly portrayed the mothers as cruel, psychopathic, and unfit, and some legislators, prosecutors, and advocates expressed support for jailing women in order to protect fetuses (Gomez 1997; Haack 1997). Yet despite the rhetoric demonizing drug and alcohol using women (Armstrong 2003; Humphries 1999), no statutes criminalizing pregnant women passed during the 1974-2000 period.[104]

Criminalization's failure to launch was a specifically legislative phenomenon. Prosecutors could and do prosecute women for substance use during pregnancy, seeking to jail them for the offense. Yet they do so on a case-by-case basis, and when appealed, convictions are nearly always overturned. The only two states that systematically criminalize women—South Carolina and Alabama—did (and continue to do) so under the authority of state supreme court rulings issued in 1997 and 2013 respectively, not legislative statutes.[105] Prosecutors in those two

[104] Note that, by contrast, states passed a significant number of laws, many still in existence, that criminalize third-party harm to fetuses or pregnant women. These include laws that ban sale of drugs to pregnant women, as well as laws that criminalize people who assault pregnant women, resulting in fetal death. See for example a description of California third-party assault laws in notes 112 and 113, below. Some fetal homicide laws have, on a few occasions, been applied to pregnant women themselves, but they generally failed on appeal (Murphy 2014). Note also that since 2000, only one short-lived law criminalizing substance use by pregnant women has passed: Tennessee's fetal assault law, which lasted from 2014 to 2016.

[105] See Whitner v. State of South Carolina (1997); Ex parte Ankrom v. State of Alabama (2013).

states choose cases based on their own discretion and apply child abuse-related laws, which they extend to fetuses—despite the fact that the laws do not mention fetuses—on the basis of state court rulings that allow for that extension. The only known exception to this lack of criminalization statutes in the United States is the short-lived Tennessee fetal assault law (2014-2016), which criminalized women for substance use during pregnancy; it expired after two years and efforts to revive it have failed (Lewis 2016). In brief, even if individual prosecutors were willing to criminalize prenatal substance use, state legislatures during this highly contentious period were not. Instead, legislators vacillated between civil regulation options—child welfare, medical authority, or civil commitment. To explain how this legislative process unfolded, I will first provide an explanation of what civil regulation means in the United States, followed by a brief overview of the predominantly civil regulation of pregnancy. Finally, I will provide two state case studies that illustrate how civil perinatal protective policies developed during this pivotal period.

Civil Regulation in the United States

Civil regulation has particular meaning in the American legal system, which is roughly divided into civil and criminal judicial systems. Criminal law and courts deal with a range of violations of criminal law, from financial crimes to violent felonies. Civil law and courts adjudicate a broad array of non-criminal monetary, family, contract, and property disputes. There are some key distinctions in the administration of criminal and civil law: first, criminal courts operate within the larger criminal justice system, and punishment generally involves incarceration in a prison or the threat of it. Second, criminal law has relatively higher standards for conviction (a standard of "beyond a reasonable doubt," which requires overwhelming proof) and usually involves a jury trial in cases that are not settled through plea deals with prosecutors. By contrast, for most civil courts, penalties are monetary or involve some other non-carceral outcome, and standards of evidence are relatively lower; most common is the "preponderance of evidence" standard, which essentially requires evidence that proves the defendant is more likely than not to have committed the action in question.

Child welfare interventions, some court-ordered medical interventions, and civil commitment procedures usually take place in civil courts, administered by civil law. Child welfare proceedings, specifically, unfold in child welfare courts (also called dependency and family courts). In child welfare courts in particular, while most states require "clear and convincing" evidence (one level below "beyond a reasonable doubt") to permanently remove child custody, preponderance of evidence or a similar standard is all that is required to establish initial jurisdiction or to order temporary removal (Children's Bureau 2017; Feller Nusbaum et al. 1992: 15)—which could last months or years. In California, which has the largest population of children in the United States,[106] a standard of preponderance of evidence is sufficient even for permanent removal (Lee and Thue 2009). In practice, this means that a social worker's claim, even if backed by less convincing evidence, can carry significant weight in child welfare court decisions, with long-lasting consequences for families that often have few resources to contest or appeal decisions. Moreover, civil courts do not involve jury trials, and often rely on one judge for decisions; this opens possibilities of bias or abuse of power, especially so in child welfare

[106] At 9.1 million, California's child population is larger than many countries. See state population data from the Kaiser Family Foundation, based on the 2008-2019 American Community Survey, 1-Year Estimates, here: https://www.kff.org/other/state-indicator/distribution-by-age, accessed June 4, 2021.

courts, where due to concerns of privacy, trial proceedings are kept confidential. A lack of transparency, even if justified by the need for privacy, can also mean less accountability and potentially less consistency in how laws are enforced in dependency proceedings.

Civil Regulation of Pregnancy

The civil regulation of pregnancy has deep roots in American legal history. In recent decades, we have seen a move toward civil regulation in multiple areas of pregnancy-related issues. Many states allow for the appointment of legal representatives, known as guardians ad litem (GAL), for fetuses in trust and probate proceedings (usually involving inheritance). Courts have also upheld claims of civil damages for harm to unborn children, usually alleged from a third-party, but also from the mother as well (Bonner and Sheriff 2012).[107] While civil cases against mothers for prenatal harm generally involve child welfare petitions, there have also been civil claims for monetary damages, which have helped reinforce ideas of fetal personhood (Schroedel 2000). One study found a shift in how cases involving maternal-fetal conflict are adjudicated over time. Cases in the 1940s through the 1960s were usually only found in favor of fetuses if the fetus was viable or was born alive, and generally saw the fetus as integrally part of the mother, not an independent person. By the late 1970s, fetuses were increasingly seen as distinct beings and potentially in conflict with their mother. The study found that out of 35 civil cases that occurred from 1978 to 1998, mostly involving prenatal neglect by the mother, only six cases were found in favor of the mother; the vast majority, 29, were found in favor of the fetus—indicating how civil cases may be more likely to go against mothers, in part because they are perceived as less harmful to them than criminal cases, which are overwhelmingly overturned on appeal (Riches 2001: 142-143, 183).

While the cases above deal with monetary damages for prenatal harm or monetary loss, more coercive interventions in the civil realm also occur, especially in medical situations. In some cases, brain-dead women were kept artificially alive to ensure the survival of their fetus, sometimes against the wishes of their family (Bonner and Sheriff 2012; Rahders 2016). There are also multiple cases of forced medical interventions, some of which unfold through civil courts, where women are compelled to undergo procedures deemed to benefit their fetus regardless of their wishes (Paltrow and Flavin 2013; Pratt 2013).

Civil interventions in substance-exposed infants are common, with tens of thousands of infants reported a year to child welfare. The most common type of procedure is a dependency hearing, in which child welfare workers argue before a judge regarding the capacity of the mother to care for a child in the case of prenatal substance use. A far less commonly used intervention is civil commitment, in which women suspected of substance use during pregnancy are held involuntarily in a non-jail setting. Civil commitment is technically legal in multiple states, with five states explicitly allowing it in cases of prenatal substance use. While fiercely debated in the early to mid-1990s, some professionals (largely in the political science and legal fields) promoted civil commitment as the appropriate solution to balancing maternal and fetal rights (Chavkin 1996; Mathieu 1995; Peretz and Schroedel 1996). As I will show, however, even

[107] Precedent for monetary compensation for third-party damage to fetuses can be traced to the Old Testament, which cites a case in which a pregnant woman caught in a conflict between two men is assaulted, terminating her pregnancy. The text then states that assailant should pay monetary compensation for the loss. This is in contrast to the capital punishment that the Old Testament mandates in cases of murder of a living person, indicating that the fetus is not seen as the equivalent of a born human (Exodus 21: 22).

when civil commitment proceedings are used, child welfare agencies are deeply involved in interventions after birth.

Understanding the failure of criminalization and the rise of civil regulation, predominantly child welfare regulation, in cases of substance-exposed infants requires a deeper examination of how states developed their policies during this period. The next section provides an overview of state-level perinatal protective policies across the United States, followed by two case studies that illustrate the trajectories of civil regulation in the United States: California, representing the most common path, the failure of criminalization and the authorization of child welfare, and Wisconsin, the less common path—he failure of criminalization and the authorization of civil commitment proceedings, with involvement by child welfare.

State Policy on the Ground

From 1970-2016, states passed a variety of laws regulating interventions in cases of substance-exposed infants. Figure 14 displays the cumulative total of state laws passed by specific year, organized into five categories of law. For example, by 1990, six states had passed laws classifying prenatal substance use as child abuse or neglect, and four states had passed laws mandating the reporting of substance-exposed infants (SEI) to social services. This jumped to nine each by 1997; note that these data reflect only formal statutes and do not include informal policies, which are standard in state regulation. Indeed, in 1990, nineteen states reported that they had a policy, either formal or informal, mandating that medical professionals report SEI to child welfare (Daro and Mccurdy 1991: 21); 42 states reported formal or informal policies mandated reporting to child welfare agencies by 2018, although only 20-25 (it varied by year) had formal statutes (Child Welfare 2019; GAO 2018). Figure 14 shows that the vast majority of these formal laws (57 in total) shift responsibility to social services, including laws that categorize substance abuse as child abuse, mandate reporting to child welfare, and specifically outlaw criminalization.[108] I categorize laws that mandate civil commitment of these women (five state laws in total) separately because they usually involve a mixture of social service and medical professionals as authority. However, as shown in the Wisconsin case study in this chapter, civil commitment can heavily involve child welfare services. Finally, the only law mandating criminalization passed in Tennessee in 2014 and expired by 2016. In effect, the vast majority of the laws passed reinforce child welfare and social services as the primary authority over this issue.

We can conceive of these laws as a spectrum of civil regulation, with social services at one end, civil commitment as a form of more coercive civil surveillance in the middle, and criminal sanctions at the other end. This chapter will focus on case studies selected to represent the two most common parts of this spectrum—social services and civil commitment. California represents social services, as one of the earliest adopters of comprehensive child welfare regulation of SEI and as a state with one of the largest child populations affected. Wisconsin represents a state that not only adopted civil commitment policy as law, but implemented it with relative consistency, heavily involving child welfare agencies, and publicly defending it in a

[108] While it is clear that mandated reporting to child welfare or classifying prenatal substance use as child abuse or neglect will shift interventions to child welfare, the other categories are perhaps less direct but still effective at doing so: legislation that outlaws criminalization in effect means that child welfare is the most likely alternative regulating authority, and, as demonstrated in the Wisconsin case study below, civil commitment could heavily involve child welfare services. Note that while some laws that categorized prenatal substance use as abuse or neglect could be used for criminal prosecution of mothers, this is relatively infrequent, as compared to child welfare interventions.

court case in recent years (Loertscher v. Anderson 2018). There is no case study of criminalization because it is well covered in prior literature (Amnesty International 2017; Howard 2017; Lewis 2016), and it does not explain the main argument of this chapter: the expansion of civil regulation of substance-exposed infants. Instead, criminalization—both the least common and most heavily researched category in prior literature—functions as a question in this analysis, specifically the question of why it has so frequently failed to become law.

Importantly, the states that passed laws empowering civil services like child welfare were governed by legislatures and governors ranging from conservative—including Kentucky and South Dakota—to liberal, such as Massachusetts and California. The two case studies below, representing largely Democrat and Republican controlled state legislatures respectively, show that while the rhetoric may differ, both conservative- and liberal-leaning legislatures ultimately sought to empower child welfare as the primary regulators in cases of substance-exposed infants. The bipartisan legitimation of child welfare's authority indicates the widespread institutionalization of child welfare as a legitimate regulator of American families across the political spectrum by the 1990s. Examining these two states sheds important light on how child welfare not only became the predominant authority in regulating substance-exposed infants and their mothers, but how a risk-focused framing of family regulation, supported by an expanded infrastructural capacity for interventions, enabled the passage of perinatal protective laws.

California

This section outlines California's response to the issue of substance-exposed infants, beginning with failed attempts at criminalization and medical authority, and then shifting to child welfare agencies as the primary regulators. Issues of substance exposure and harm to fetuses long presented a legislative and moral dilemma for California policymakers, health providers, and social service professionals. In the initial stages, beginning in the 1970s, some lawmakers and prosecutors sought punitive criminalization of adults who harmed fetuses (usually parents), especially if such harm extended to symptoms after birth. These attempts at criminalization proceeded along two paths: litigation, or cases brought by local prosecutors against individuals, and state legislation. With some minor exceptions, both of these ultimately failed.

The 1970s: The Child-Fetus Distinction

The case of Margaret Velasquez Reyes in 1977 was the first in California (and according to some sources, in the US)[109] that brought this issue to the fore. According to the court decision, Reyes, a pregnant heroin user, ignored warnings from a nurse that her heroin use could harm or even kill her children, continuing to use heroin in the last months of her pregnancy (Reyes v. Superior Court, 141 Cal. Rptr. 912 [Cal. Ct. App. 1977]). She gave birth to twin boys, both of whom suffered from heroin withdrawal symptoms, but were otherwise in good health. Within a few months, she was charged by the San Bernardino district attorney office with "felony child endangerment," in violation of California Penal Code s. 273. Upon appeal, the case was dismissed because, the court ruled, a fetus is not a child, a decision the judges supported by

[109] Note that because lower-tier court records are often not made public, it is difficult to ascertain what was the first case of this kind. There is no comprehensive database of court cases, or even a reliably systematic review of cases related to this issue. The closest to this is a study of cases from 1973-2011, which is not a comprehensive history (Paltrow and Flavin 2013). However, some scholars refer to Reyes as the first case that sought to criminalize mothers for prenatal substance use (Fentiman 2006; Murray and Luker 2014), and I rely on their scholarship for this case study.

citing cases in which a fetus was not considered a child for purposes of murder, failure to provide, or (citing Roe v. Wade 1973) for privacy purposes. The court also argued that when the legislature seeks to include a fetus in the definition of the child, it is explicit about it. For example, Penal Code s. 270 expressly extends a father's obligation to support a child "not yet born." Similarly, the legislature extended the murder statute in 1970 to include a "human being or a fetus" in some cases (California Penal Code s. 187).

The 1980s: Controversy and Heightened Criminalization Efforts

The Reyes decision set a precedent in California, in which law agencies could not assume child abuse statutes could be applied to fetuses. Yet discourses around issues of prenatal care were shifting by the mid-1980s. These changes are usually attributed to increasing media attention to drug use, especially an intensive (and likely disproportionate) focus on crack cocaine use by poor mothers of color, as well as to concerns for fetal well-being linked to increasing debates around abortion (see Chapter 5). These controversies converged on a widely covered case in California: In 1985, Pamela Rae Stewart gave birth to a brain-damaged baby, who died a few weeks later. Eight months later, the San Diego DA office charged Stewart with criminal child neglect under Penal Code s. 270, which explicitly extends responsibility for criminal child neglect to include a "child conceived but not yet born." The prosecutor argued that Stewart had used drugs and had intercourse with her husband against doctor's orders at the end of her pregnancy and was thus responsible for the death of her child. A San Diego municipal judge dismissed the case in 1987 on the grounds that the extension of the law was specifically to force men to support women they had impregnated, and not to criminalize pregnant women for their behavior (Thompson 1989). This time, however, the matter did not simply fade. Unlike the Reyes case, on which there seems to have been only limited media coverage, there was significant coverage of the Stewart case in California, with editorials and articles debating the merits of the case.[110] And in contrast with the straightforward dismissal in the Reyes case, the judge, in the decision dismissing the Stewart case, explicitly urged the legislature to pass a law "protecting the life of the unborn child under certain narrowly defined conditions" (cited in Thompson 1989, n. 7).

Whether encouraged by media coverage or by the judge's statement, or both, the late 1980s saw a wave of legislation attempting to criminalize substance use during pregnancy in California. These laws were written to provide a legislative basis for prosecuting pregnant women for prenatal behaviors, thus enabling prosecutions to proceed without dismissal from judges on the grounds of a lack of legislative basis. The first such bill, Senate Bill (SB) 1070 in 1987, was explicitly described by one of its sponsors as inspired by the Stewart case (Carson 1987), yet the bill, as well as two other similar bills, quickly failed. All were sponsored entirely by Republican men and could not make it past the Democratic controlled legislature.[111]

---

[110] The *Los Angeles Times* has only one article regarding the Reyes case between 1975-1990 but shows 21 relevant articles on the Stewart case from 1985-1990, which is at least a limited indication of a difference in media coverage between these two cases. However, these limited findings for the Reyes case (one relevant article in the *Los Angeles Times* versus 63 relevant articles in all California newspapers for the Stewart case) may be partially due to the fact that, other than the *Los Angeles Times*, most digitized California newspaper sources do not extend further back than the mid-1980s. It is possible that other newspapers more thoroughly covered the Reyes case, but I am relying on the *Los Angeles Times*, a flagship California newspaper, as a barometer for broader coverage.

[111] Information on bill sponsorship and legal histories can be found in California legislative histories, organized by date and bill number, located in the University of California, Berkeley Law School library.

Only one bill, SB 1465 (1989), generated substantive discussion. Sponsored by John Seymour, a moderate Republican who supported progressive causes like gun control, education, mental health, and anti-discrimination measures for HIV-AIDS victims, the bill hearings attracted advocates on both sides. The Seymour-sponsored SB 1465 was seen as a "carrot and stick" approach because it provided and prioritized treatment for pregnant women, and it only allowed for prosecution in cases in which the pregnant woman intentionally refused treatment and in which the child was born alive and then died for reasons primarily due to substance use. Yet this bill also ultimately failed to make it to a floor vote, due both to overwhelming opposition by Democrat lawmakers who constituted the legislature's majority, as well as ongoing professional lobbying efforts by medical associations and pro-abortion choice advocates (Gomez 1997).

The 1990s: Decline of Criminalization Efforts

Despite the failure of these legislative efforts, there were some continuing efforts to criminalize pregnant women through litigation efforts in the early and mid-1990s. Most, however, ended in failure or dismissal of charges, especially when appealed. An example is the Roseann Jaurigue case in 1993, in which Jaurigue gave birth to a stillborn child after using cocaine. She was charged with second degree murder under California's Penal Code s. 187, the state's murder statute, which had been extended in 1970 to include fetuses, with a clear exception for abortion. Prosecutors argued that the specific exception for abortion implied that maternal drug use was not, in fact, exempted from the murder law. However, the judge ruled to dismiss the charges based on this legislative ambiguity (Hager 1992a, 1992b).[112]

Gomez (1997) argues that litigious responses to substance use during pregnancy were dependent on specific approaches of California's county-based DA offices, which mirrored responses across the country: extremely punitive, moderate, weak, with even the "extreme" prosecutors only pursuing a handful of cases. Gomez reports on only one known California case in which a woman was successfully convicted of criminal child neglect for prenatal and postpartum ingestion of meth, and actually served a prison sentence. Gomez also notes vague reports of unpublished cases involving guilty plea deals in Riverside county in the mid-1990s, but notes that prosecutors refused to share details of these cases, in part, she theorizes, out of fear that such cases would be dismissed on appeal. With these exceptions, it appears that backed by neither legislative action, nor medical or social welfare agencies support, litigation to criminalize prenatal behavior largely stalled by the mid-1990s (Gomez 1997).[113]

---

[112] This same law, California Penal Code s. 187, was used to uphold third-person fetal manslaughter charges against a man who assaulted a pregnant woman, ending in fetal death (People v. Davis, 1994). The ruling aroused some outraged responses, pointing to the fact that California simultaneously allows some of the most liberal abortion laws in the nation, while upholding some of the strictest interpretations of fetal manslaughter by a third party (Dolan 1994).

[113] On the legislative side, criminalization efforts continued in an attenuated form, primarily focused on third parties, not pregnant women. Two exceptions were Assembly Bill (AB) 2614 in 1995, a bill that criminalized "prenatal neglect" and AB 2187 (1998), which defined substance exposure of fetuses as child abuse; both failed on partisan lines. Legislative efforts to criminalize fetal miscarriage due to vehicular accidents also failed on partisan lines (for example, the failures of AB 2691 in 1995 and AB 2178 in 1998), while criminalization of drug sales to pregnant women was eventually passed into law, after five failed attempts, in AB 42 (1992). The passed version was sponsored by Democratic legislators and received bipartisan support. The fact that AB 42 eventually received sponsorship from Democrats and Republicans indicates an arguably paradoxical distinction that emerged in

Explaining the Failure of Criminalization

Existing scholarship attributes the failure of legislative efforts to criminalize women for prenatal substance use to two overlapping factors: First, the California legislature was controlled by Democrats, who were wary of any laws that might be construed as limitations on women's autonomy or that could eventually be extended to restrictions on abortion. Criminalization bills were sponsored overwhelmingly by Republican men, and they failed almost entirely on party and gendered lines.[114] Yet partisanship is only part of the story, one that does not explain broader national trends to pass legislation empowering child welfare across both Republican and Democrat-dominated state legislatures.[115] A second factor discussed in published research is the role of advocacy. During the 1980s, a large network of professional lobbyists and grassroots activists fought any criminalization of pregnant women in California (Gomez 1997). These lobbyists and activists could be divided into roughly two groups: pro-choice groups like the American Civil Liberties Union (ACLU), which would defend women like Roseann Jaurigue, and professional lobbyists for medical and child health groups, such as the California Medical Association (CMA), the California Advocates for Pregnant Women (mostly composed of public health nurses) and March of Dimes, an infant health organization. Gomez argues that lobbyists and grassroots activists reframed prenatal substance use as a medical issue that belonged under medical providers' jurisdiction. According to this framing, such advocacy efforts, supported by pro-choice advocates and a Democrat-controlled legislature, primarily reinforced medical authority in the bills that did pass. While Gomez acknowledges that child welfare agencies were also gatekeepers of this issue and that ultimately they too received jurisdiction, she describes them as working together with medical authorities on essentially equal footing, and does not have any explanation for why child welfare became an authority, when legislative advocacy related to this issue in California was overwhelmingly conducted by medical and legal organizations, not child welfare.

However, this chapter's findings provide an alternative account. Gomez—and some other scholars (Amnesty International 2017; Cherry 2007; Mohapatra 2011)—conflate criminalization with a punitive approach and the medical and social welfare interventions with a supportive approach that frames substance-using women as victims. In the California case, Gomez shows that this punitive criminalization approach failed, while the supportive medical (primarily) and social services (secondarily) approach triumphed. Yet the evidence laid out in this chapter shows that efforts to authorize medical professionals as the main authorities to intervene in this issue failed, while child welfare was in fact the primary profession assigned intervention authority. Even though the legislative advocacy overwhelming pushed for a supportive medical framing, that did not happen in the law. Prior scholarship misses the important role of the institutionalization of child welfare as a risk-focused protective authority in guiding policy

---

California: lawmakers consistently shied away from criminalizing women for perinatal behaviors, yet they were willing to criminalize third-party actors for harming fetuses.

[114] Note, however, that the bills related to SEI that were passed into law (SB 2669 and AB 3010, primarily, as described below) were signed by Republican governors of California: George Deukmejian and Pete Wilson.

[115] An explanation focused on partisanship might clarify why legislative criminalization failed in CA, but it does not explain why efforts to criminalize prenatal substance use failed in every other state, with the exception of a short-lived law in Tennessee (2014-2016). I argue that this indicates that partisanship alone cannot explain this legislative phenomenon; this is a broader institutional and cultural issue, in which legislators across the nation saw legitimizing child welfare interventions as more appealing and more legitimate than criminalization. This also complicates the assumption that progressives advocated for supportive responses to SEI, when in fact the child welfare responses these progressive advocates promoted were often quite punitive in practice.

outcomes. In fact, as I will show, the uniquely coercive power of child welfare, coupled with its infrastructural capacity, motivated progressive Democrats in California to advocate for child welfare as the primary authority over this issue.

The Growth of Child Welfare Authority

This section lays out how child welfare's infrastructural capacity and its jurisdiction to intervene in families in California expanded, and how this shaped regulatory outcomes for perinatal interventions. The second half of the twentieth century saw important shifts in California toward expanding child welfare agencies' regulatory authority over families. Many child neglect and abuse cases were originally handled by local probation departments, which focused on delinquency and other child welfare issues. By 1968, however, the legislature shifted many of the duties related to child "dependency" to child welfare services,[116] which were further empowered by the passage of SB 14 in 1982. SB 14 expanded and specified the role of child welfare services in cases of child maltreatment, while also increasing and streamlining funding flows, thus expanding child welfare's infrastructure, even as child welfare narrowed its jurisdiction to focus on child maltreatment.

Legislative Timeline: Expansion of Child Welfare Authority in California, 1968-1998

- 1968, AB 1924: Jurisdictional shift of abuse and neglect cases from probation to social services departments.
- 1973, AB 1012: Parental "habitual" substance use justifies intervention by child welfare.
- 1982, SB 14: Expansion of funding and regulatory role of child welfare agencies.
- 1987, SB 243: Streamlining of child removal process.
- 1997-1998, AB 2772: The federal Adoption and Safe Families Act (ASFA, P.L. 105-89) shortens reunification times, increasing the probability of parental termination; it was implemented in California through Assembly Bill (AB) 2772, passed in 1998.

In 1987, SB 243, sponsored by Sen. Robert Presley (D), significantly revised Welfare and Institutions Code section 300, which focuses on child welfare responses to neglect and maltreatment. This bill, which passed into law, sought to narrow the conditions for child removal, specifying clearer definitions of abuse and neglect that justify interventions, providing parents with a right to an attorney, and shortening the process to termination, in an attempt to streamline and improve child welfare case processing and reduce child removals. When faced with critiques from children's advocates that this would abandon abused children, Presley argued that the bill provides guidelines on assessing "risk" in order to ensure children are kept safe, language that echoes the risk-focused discourses of child welfare at the time. A focus on risk also incorporated a focus on the environmental conditions of the child's home, irrespective of parents' ability or intent to provide. This framing was explicated in two letters to Sen. Seymour, where the writers explicitly argued that the revised law should not account for parents' intentions

[116] AB 1924 (signed into law on August 8, 1968) revised what is now s. 272 of the Welfare and Institutions Code of California, shifting county responsibilities for "dependent children"—meaning children for whom the state bore responsibility—from the probation to the county welfare departments.

in formulating procedures for child removal.[117] This indicates a broader concern for the child's safety in a framing that separates, in effect opposing, children's well-being and parental well-being. Ironically, despite the goal of reducing removals, the law's administrative streamlining of the child removal process made it easier to transform temporary removal procedures into permanent ones and gave parents less time to resolve issues linked to their separation from their children.[118] Ultimately, the intended impact of decreasing removals may have been unintentionally structured to fail.[119] In the following years, the number of children entering foster care in California rose steadily, from 28,360 in 1988 to 33,306 in 1994.[120]

California Social Services and SEI

While criminalization of substance-using pregnant women resoundingly failed in California, more than seventy social service-based bills focused on prenatal substance use were proposed in the legislature from 1986-2000. Most of these failed or made only incremental changes. There were, however, two significant developments that reshaped the SEI policy landscape: first, the 1989 Budget Act of California included an item to fund the Perinatal Substance Abuse Pilot Project, in which the California Departments of Health Services (DHS), Social Services (DSS) and Alcohol and Drug Programs (DADP) worked together on pilot projects for services related to SEI in five California counties.[121] The Perinatal Project shifted attention away from criminalization to social-service based efforts such as counseling and service referrals for substance-using women. Yet there was little clear evidence of whether or not the programs actually helped, and concerns about the number of substance-affected infants continued to mount in the following years. Considering the relatively low project funding and the

[117] See letter from Solano County Counsel, June 23, 1987, in SB 243 1987 LP347_ 132-179, California State Archives, Sacramento CA, and letter from CA State Child Development Programs Advisory Committee, June 6, 1987, in CSA - SB 243 1987 LP347 142, California State Archives, Sacramento CA.

[118] This was further reinforced by the 1997 passage of Adoption and Safe Families Act (ASFA) a federal law that shortened times for children in foster care and arguably made it considerably more difficult for parents whose children were removed due to parental drug use to regain custody (Fentiman 2006: 582).

[119] This effect may be partially linked to the bill's language. The narrowed definitions, while attempting to be more specific than the previous ones, were still considerably vague, leaving leeway for significant decision-making power by social workers, who were incentivized by funding differentials—with more funding for foster care than in-home services—and high caseloads to resort to family separation as a solution for complex multi-system problems.

[120] Foster care data for 1985-1986 are available through reports from VCIS (Voluntary Cooperation Information System), the system for collecting data on foster care and adoption that preceded the current Adoption and Foster Care Analysis and Reporting System (AFCARS). These specific numbers are from the following VCIS reports: "Analysis of State Child Welfare Data: VCIS Data from 1986, 1987, and 1988" (U.S. Department of Health and Human Services, in collaboration with Caliber Associates Maximus Inc., 1992), p. 14, and "Analysis of State Child Welfare Data: VCIS Data from 1990 through 1994" (U.S. Department of Health and Human Services, in collaboration with Caliber Associates, 1998), p. II-10.

[121] The 1989 California state funding report entitled "State Spending Plan for 1989-90," provides further details on the funding for the Perinatal Project on pp. 19-20; a copy of the bill is available online at https://lao.ca.gov/reports/1989/0889_state_spending_plan.pdf, accessed June 20, 2021. More information on the Perinatal Project is also available in a document produced by the California Department of Alcohol and Drug Programs (DADP) in December 2002, entitled "Fact Sheet: The History of Perinatal Substance Abuse Services in California." The fact sheet is available at this link: https://fhop.ucsf.edu/sites/fhop.ucsf.edu/files/wysiwyg/ip_historyPerinatSubstUse.pdf , accessed June 20, 2021. Funding for the project was renewed in the 1990 budget, and in 1997, the California legislature made Options for Recovery, one of the main treatment programs funded by this project, a permanent program under DADP (Assembly Bill 67, 1997, amending section 16525.10 of the California Welfare and Institutions Code).

growing number of reports of SEI, the Sacramento Bee called the project "pathetically inadequate" when it was founded (Sacramento Bee 1989). Second, and perhaps most importantly, was the passage of SB 2669, described in the next section. The circuitous passage of this bill indicates the rise and fall of medical professionals as the potential primary authority in California's perinatal regulation, explaining the shift to child welfare.

The Rejection of Medical Authority and the Rise of Child Welfare

In 1991, the California legislature passed SB 2669, the Perinatal Substance Abuse Services Act, a law focused specifically on substance use during pregnancy. SB 2669 required, in cases of positive toxicology test at birth that (unspecified, but presumably mandated professional reporters) determine if there is additional risk to child assessed, and if so, to then report the case to social services, in effect, child welfare. Reporters are specifically prohibited from reporting the case to law enforcement. This is significant because it signals the formal authorization of child welfare as the authority for reports; note that this legal language is still the current law, with minor revisions (California Penal Code s. 1165.13).

SB 2669 gained support in large part due to the early versions of the bill, which emphasized a comprehensive medical approach and included a prohibition on reporting to law enforcement. Specifically, the bill originally sought to assign public health (PH) nurses to intervene in cases of positive toxicology tests; child welfare services would only be called in if the nurse decides this is necessary after a home visit and assessment. This emphasis on a comprehensive medical approach inspired multiple letters of support from local California public health departments, district attorney offices, and at least seven major medical associations.[122] The letters praised the bill for focusing on SEI as a health issue, not a criminal or moral one, and commended it for a providing a comprehensive, "family oriented" treatment approach that, as the Commission on the Status of Women wrote in its supportive letter to bill sponsor Robert Presley, would "promote the welfare of both mother and child."[123] The American Academy of Pediatrics wrote a letter praising the bill for its full range of services:

> In providing comprehensive treatment services for drug-exposed newborns, their mothers and families, this bill offers a constructive solution to a large and growing problem. In proscribing mandatory reporting of positive drug screens, it offers hope that pregnant drug users will not hesitate to seek prenatal care for fear of prosecution. This is undoubtedly in the best interests of children and families.[124]

The emphasis on "comprehensive treatment services" pointed at support for a bill that would aid mothers and their children in a unified way. This approach built on a medically grounded consensual counseling method (see Chapter 5), which sought to recognize the interrelated needs of mothers and babies, and which precluded criminalization and viewed even

[122] See files of Sen. Presley, SB 2669 (1990), LP 347: 239 D1030 p2, California State Archives, Sacramento, California; the number of associations is also cited in the dissertation of Gomez, on which her 1997 book is based (Gomez 1994).
[123] Letter from Jan Hall, chair of the Commission on the Status of Women - California, May 3, 1990, in the files of Sen. Presley, SB 2669 (1990), LP 347: 239 D1030 p2, California State Archives, Sacramento, California.
[124] Letter from Robert Black, Chairman, Committee on State Legislation, American Academy of Pediatrics – California District, May 16, 1990, in the files of Sen. Presley, SB 2669 (1990), LP 347: 239 D1030 p2, California State Archives, Sacramento, California.

child welfare services as secondary. Yet despite this outpouring of support, the role of medical professionals in this bill disappeared during revisions.

How did this happen? Why did the role of medical professionals, the main reason for widespread enthusiastic support for the legislation, disappear from the primary policy regulating prenatal substance use in California? An answer to this question can be found in the letters and supporting materials for the bill. Among the letters of support emerge additional documents voicing professional concerns and outright opposition to the bill, opposition that hinged on the non-coercive authority of medical professionals. This opposition took different forms, but converged on the idea that child welfare's mixture of protective legitimacy and coercive authority, reinforced by a widespread infrastructure, made it the more appropriate authority than medical professionals to intervene in cases of substance-exposed infants.

This idea comes through in a variety of ways in the archival materials for SB 2669. The California Public Health Association-North supported the bill, but expressed concern that the bill "mandates an investigative, "policing" role" for public health nurses, which will cause them to be viewed as "an extension of CPS"[125] and would "weaken their effectiveness as case managers."[126] That is, public health nurses did not view their role as one of investigation or surveillance, and did not want to be associated with the coercive authority of child welfare. A somewhat different perspective was evident in a letter from the California Nurses Association, which expressed concern about the lack of police protection for public health nurses in what they perceived would be dangerous situations that the association writers believed required a police support; in contrast, they argued that child welfare would receive police protection.[127] Most directly, Caroline Cotta, the director of Social Services at a California medical center opposed the bill because "[t]he proposed shift of referral pattern from Child Protective Services (CPS) to the Public Health Nurse (PHN) is of deep concern to our department and the health care professionals working with this client population." Cotta expressed concerns related to inadequate nurse staffing, presumably relative to a larger child welfare worker workforce, and to the voluntary nature of medical supervision: "The Community Health Services PHN program is a voluntary agency. If the client refuses to participate in the program, the case is closed."[128]

This support for the coercive authority of child welfare is noted explicitly in a letter by director of UCLA pediatrics division, Dr. Judith Howard, who wrote that she has "grave concerns" that reports of SEI will not be automatically referred to child welfare services, which, she argued, should work in collaboration with medical professionals. Dr. Howard stated that child protective services is vital because: "In our experience, the clout of protective services agency involvement at the critical time of birth often can provide the impetus and structure to

---

[125] CPS refers to child protective services and is used interchangeably with child welfare services in this context. See Chapter 3, note 44.

[126] Letter from California Public Health Association–North, May 31, 1990, in the files of Sen. Presley, SB 2669 (1990), LP 347: 239 D1030 p2, California State Archives, Sacramento, California.

[127] Letter from Beth Capell, legislative advocate for the California Nurses Association, May 3, 1990, in the files of Sen. Presley, SB 2669 (1990), LP 347: 239 D1030 p2, California State Archives, Sacramento, California.

[128] Letter from Carolyn Cotta, Director of Social Services at the Doctor's Medical Center, Modesto, California, August 6, 1990, in the files of the Assembly Committee on Health – 2669 (1990) – OFP Andrew, California State Archives, Sacramento, California. Underlining in the original text. The letter was accompanied by a sample case study report of a client, a cocaine-using mother with a history of testing positive during pregnancy—although she and her baby tested negative at delivery, who stopped accepting public health nursing services.

help a substance-abusing mother address the problems of addiction..."[129] "Clout" is another way of describing the coercive authority of child welfare, which the doctor saw as crucial to successful treatment.

Ultimately, despite the many letters that praised and supported collaborative and medically-based services, public health nurses were removed entirely from the revised version of the bill that passed into law. The Health Department report in the files that accompanied the final bill for the governor signing noted that "…provisions [providing a "significant role" to PHN] were deleted in response to Department of Social Services concerns that they diluted county welfare departments' ability to protect infants" and because public health nurses did not want to be "involved in/identified with law enforcement activities."[130] Ultimately SB 2669 passed because child welfare was seen as the right mixture of coercive and protective authority, in line with a focus on reducing risk. As the final text of the law noted, the goal was to assess and reduce risk to the child's health, risk based on a combination of a positive toxicology test and other unspecified factors:

> "For purposes of this article, a positive toxicology screen at the time of the delivery of an infant is not in and of itself a sufficient basis for reporting child abuse or neglect. However, any indication of maternal substance abuse shall lead to an assessment of the needs of the mother and child …If other factors are present that indicate risk to a child, then a report shall be made. However, a report based on risk to a child which relates solely to the inability of the parent to provide the child with regular care due to the parent's substance abuse shall be made only to a county welfare or probation department and not to a law enforcement agency" (California Penal Code s. 11165.3).

The bill that became law, still in force in California, focused on a risk assessment requirement for medical professionals, and provided the key responsibility for intervention to child welfare authority. Medical professionals remained at the front line, deciding if the child should be reported, but available data indicates that the majority of SEI cases are reported to child welfare (Putnam-Hornstein, Prindle, and Leventhal 2016), and child welfare remains the ultimate authority regarding such interventions. Broader social services, including drug treatment, remained in force, but they constituted a relatively small percentage of the response to SEI. These services were reinforced by the 1991 passage of SB 3010, which established the Office of Perinatal Substance Abuse, (OPSA) to coordinate services for substance-using pregnant women and SEI. OPSA assisted in programming for the perinatal substance abuse project, primarily the Options for Recovery programs for substance-using pregnant women, and a range of SEI-related issues.[131] Preliminary research revealed some success with the Options for Recovery Programs (Brindis, Clayson, and Berkowitz 1997), but the programs served a very

---

[129] Letter from Judy Howard, Professor of Clinical Pediatrics, UCLA, May 11, 1990, in the files of Sen. Presley, SB 2669 (1990), LP 347: 239 D1030 p2, California State Archives, Sacramento, California.

[130] See enrolled bill report entitled "Maternal Substance Abuse, Risk Assessment, and Child Abuse Reporting," from the California Health and Welfare Agency, Health Services Department, in the governor files for SB 2669, chapter 1603 of the California Statutes of 1990 (accessible on microfilm in the University of California, Berkeley Law School library and in the California State Archives in Sacramento, California). Note that this shift away from medical authority echoed a similar revision process in SB 1173 (1989 – passed), in which earlier versions of that bill gave doctors significant responsibility for managing care of substance-exposed infants and later versions transferred that authority primarily to social services.

[131] See the California Department of Alcohol and Drug Programs in December 2002: "Fact Sheet: The History of Perinatal Substance Abuse Services in California." The fact sheet is available at this link: https://fhop.ucsf.edu/sites/fhop.ucsf.edu/files/wysiwyg/ip_historyPerinatSubstUse.pdf , accessed June 20, 2021.

small number of women relative to those in need and did not significantly impact rising numbers of child removals likely related to SEI.

Both SB 2669 and AB 3010 constituted a response to concerns, as evidenced in archival materials for the bills, about a rising wave of substance-exposed infants that would overwhelm hospitals and eventually schools with children permanently damaged by prenatal substance use and requiring intensive and expensive care. These concerns never actually came to pass.[132] The passage of these bills in 1990-1991 were seen by medical professionals and women's advocates as a triumph for women's health. It provided a consistent procedure for responding to substance-exposed infants where none had existed, forbade criminalization, and enabled medical professionals to act as a buffer between substance-using women and child welfare. Yet ultimately, it was a triumph of child welfare authority, with health professionals' interventions minimized in favor of a maltreatment-focused response. In 2006, 53.4% of infants diagnosed with prenatal substance exposure (N = 7428) in California were reported to child welfare agencies; 40.6% of all reported infant cases that year were substance-exposed infants. Reporting ranged widely by type of substance exposure—from 36.1% of infants with alcohol exposure to 72.1% of infants with cocaine exposure, despite the known higher risks of alcohol exposure (Putnam-Hornstein et al. 2016). Child welfare is now the dominant agency in CA, as it is in most American states today, to address the complex challenges of substance-exposed infants.

Wisconsin

Wisconsin represents a case study of the development of civil commitment as a policy to address issues of prenatal substance use. Civil commitment statutes in approximately 30 states could theoretically be used for pregnant women (Fentiman 2017b), and five states specifically allow civil commitment for cases of prenatal substance use, yet cases are infrequently documented outside of Wisconsin. Civil commitment is in line with the larger trend toward civil regulation of substance-using pregnant women, but it represents a more severe invasion of a woman's civil rights, forcing her to remain in an enclosed non-jail setting under close supervision, and generally involving child welfare authorities who may seize custody of her child upon birth. Because it is a civil procedure, standards of evidence are relatively lower than they would be in a criminal court and there are fewer avenues for legal recourse for the woman.

While civil commitment can involve multiple professional disciplines, the passage of Wisconsin's law was deeply intertwined with assumptions about the risk-focused protectionist authority of child welfare. As this chapter shows, the bill's passage relied on both the legitimacy of child welfare's protective authority and its available infrastructure to enable civil regulation of substance-using women and their fetuses and children. The bill built on a long history of services to children in Wisconsin, dating from 1881, with a comprehensive Children's Code in 1929.

---

[132] For example, a letter from Senator Presley, the sponsor of SB 2669, to then California Governor Deukmejian urging him to sign the bill, argues that between 11-25% of children are born exposed to harmful substances (SB 2669, Governor files, University of California, Berkeley Law Library). Similarly, the files for AB 3010 contain many articles and letters related to such concerns; see AB 3010 (1990) 94-12-05 B2077 Box 313 in California State Archives in Sacramento, California. Note that even if more than 10% of Californian pregnant women used a substance at some point during pregnancy, the assumption that all of these children would end up severely damaged was inaccurate, as research published in the 1980s already showed (see Chapter 5). In an interview with the dissertation author, a former California legislator who was politically active in California during this time period discussed how concerns about SEI in the 1980s and early 1990s were initially coupled with concerns about HIV-affected infants, but that the latter fears faded as HIV became a medicalized issue, which SEI never did (interview 2018.2.26).

Child welfare policies in Wisconsin are a mix of bottom-up policy initiatives, which tend to involve local agency actors, and top-down federal mandates that are integrated into state and local laws and regulations. Services are primarily county-administered, but they function in a largely state-centralized manner, with the Division of Safety and Permanence in the Department of Children and Families (DCF) formally supervising child protection state-wide.[133] It is in this context of a fairly well-regulated state child welfare system that a fetal protection policy developed in Wisconsin.

The Introduction of "Unborn Child Abuse" in Wisconsin

Like California's 1987 Stewart case, which led to a series of efforts to regulate the issue of perinatal substance use, Wisconsin's policy was motivated by a failed case of criminalization. The Wisconsin law passed in 1997, just before a massive rise in SEI-related state laws nationwide in the late 1990s (see Figure 15). Prosecutors sought to criminalize pregnant substance-using women, but, as noted above, these cases were often overturned on appeal. In this period of increased judicial and legislative attention to prenatal substance use nationwide, a court ruling in Wisconsin brought the issue to the attention of state legislators.

In 1997, the Wisconsin Supreme Court overturned a lower court ruling giving Waukesha County custody of Angela M.W.'s fetus due to her drug use during pregnancy. Much like the California Stewart 1987 ruling, the Wisconsin court's reasoning was narrowly tailored to argue that because Wisconsin's child protection law does not extend to fetuses, the county welfare services have no authority over a fetus, even in cases of maternal drug use. Specifically, the judge wrote: "Because we determine that the legislature did not intend to include a fetus within the Children's Code definition of "child," we reverse the decision of the court of appeals" (State Angela v. Kruzicki III 1997).

The response was swift. On July 31, 1997, Wisconsin state representative Bonnie Ladwig, supported by other legislators, proposed AB 463, later passed as Act 292. The bill heavily revised Chapter 48 of the Wisconsin Children's Code to include an "unborn child" as a potential ward of the state in case of abuse, "which may require the expectant mother to be taken into custody" (Wisconsin Statutes, Children's Code 48.01).[134] The law provides authority to child welfare services and courts to take full responsibility for the fetus and (later) the newborn; if the pregnant woman in question does not cooperate with the proposed plan for treatment, she may be confined to a non-prison space, such as a treatment center or hospital, under close surveillance of drug treatment and social service professionals. Because this is a civil commitment, she could not be detained in a jail for this purpose.

The passage of the law was contentious. Reproductive rights advocates and medical advocates fought against it, framing it as contrary to both women's autonomy and recommended health care practice. One child welfare agency from Dade County argued that the lack of any

[133] Information on the history and organization of Wisconsin child welfare services can be found in the *State of Wisconsin 2015-2016 Blue Book* (edited by Julie Pohlman and published by the Wisconsin Legislative Reference Bureau in Madison, Wisconsin). The *Blue Book* is available at this link: http://digital.library.wisc.edu/1711.dl/WI.WIBlueBk2015, accessed June 21, 2021. This information was confirmed in an interview with a child welfare services administrator at the Wisconsin Department of Children and Families (DCF) on August 31, 2016.

[134] For details on the bill and a legislative history, see Wisconsin Legislative Council Memorandum, October 28, 1997, in the Committee Hearing Records of the Assembly Committee on Children and Families, Wisconsin, 1997-1998 session.

funding accompanying the law would make it impossible to actually enforce.[135] The bill was pushed through a Republican-led but closely divided state government; while the senate and governor were Republican-controlled, the assembly switched from Democrat to Republican-controlled during this period. This partially explains why some aspects of the bill became more restrictive during the bill revision process. The original bill as proposed was only supposed to apply for substance use during the third trimester, but pro-life groups and the Catholic Church pushed for expansion to the entire pregnancy. In the final law, passed as Wisconsin Act 292, this was achieved, with the provisions applicable to the entire pregnancy, as noted in the reasoning provided for the law:

> To recognize the compelling need to reduce the harmful financial, societal and emotional impacts that arise and the tremendous burdens that are placed on families and the community and on the health care, social services, educational and criminal justice systems as a result of the habitual lack of self-control of expectant mothers in the use of alcoholic beverages, controlled substances or controlled substance analogs, exhibited to a severe degree, during all stages of pregnancy (Wisconsin Statutes, Children's Code: 48.01).

The language of the bill was fundamentally anti-scientific, framing substance use as the result of a lack of self-control, instead of a health issue. This framing may have reflected the sentiments of the bill's sponsors, which were largely Republicans. To pass the bill in a closely divided government and in the face of strong professional opposition, however, proponents focused specifically on the civilian control of the process and the already established coercive and protective authority of child welfare. In fact, even those critiquing the bill still expressed support for the involvement of child welfare authority. As Dave Rohlfing, of the Milwaukee Substance Abuse Services Network, wrote as part of a longer analysis of the weaknesses of the bill:

> I do think there is a limited way that AB 463 will help even prior to viability. By knowing that they could eventually come under the jurisdiction of the juvenile courts once their pregnancy is viable, pregnant women who severely abuse alcohol or drugs have a powerful incentive to get their problem under control as soon as possible."[136]

Dr. Francine Weinberg, director of a treatment program called Meta House, wrote to express opposition to the bill due to concerns women will avoid treatment to evade reporting to authorities, but also noted:

> I certainly share the concern expressed in this bill and frankly, I am not opposed to coercing people into treatment. As a matter of fact, many of the women we treat in our program are there because they have been given the choice between Meta House or losing their children. They also may have been told that if they enter Meta House, and do well, their children will be returned. These women do as well in treatment as women who knock on the door and ask for help on their own.[137]

---

[135] Letter from Severa Austin, Division Administrator of the Children, Youth and Families Division of the Dane County Department of Human Services, October 30, 1997, in the Committee Hearing Records of the Assembly Committee on Children and Families, Wisconsin, 1997-1998 session.
[136] Letter from Dr. Dave Rohlfing, representing the Milwaukee Substance Abuse Network, October 30, 1997, in the Committee Hearing Records of the Assembly Committee on Children and Families, Wisconsin, 1997-1998 session.
[137] Letter from Dr. Francine Weinberg, representing the Meta House, October 23, 1997, in the Committee Hearing Records of the Assembly Committee on Children and Families, Wisconsin, 1997-1998 session.

This support for child welfare's coercive surveillance of substance-using women, essentially using child removal as a threat, was also explicitly argued by some supporters of the bill. Yet it was framed as a positive and supportive surveillance precisely because of the civil and non-criminal legal nature of child welfare. Mary Klaver, legislative legal counsel of Wisconsin's anti-abortion "Right to Life" organization argued that the civil framing of the law meant that it would support and even "benefit" substance-using mothers:

> The general approach of this legislation is positive. It would use the children's code, rather than the criminal code to intervene on behalf of unborn children when their mothers are abusing drugs or alcohol. Detention would be a last resort when other interventions have failed and would, unlike criminal incarceration, end when the child was born. In addition, the various interventions to protect unborn children would also benefit their mothers."[138]

The bill was also defended by its sponsor as essentially in line with the institutionalization of child welfare—an organic extension of its legitimate authority. In response to multiple statements about the greater likelihood that pregnant women would avoid prenatal care if threatened with child removal and civil commitment, Representative Bonnie Ladwig argued during hearings:

> "Another objection sure to be raised today concerns the fact that AB 463 expands the Children's Code mandatory reporting requirements to unborn child abuse due to alcohol and drug abuse. Please keep in mind that these objections are the very same objections raised by certain experts back when we first required physicians, nurses, social workers and other professionals to report physical and sexual abuse of children. Back then, these experts said that parents who abused their children would no longer take their children to the doctor because they might be turned in. Or they said we should not stigmatize these parents, these parents were somehow not responsible for their abusive behavior. Well, as far as I know, no one today suggests that doctors should not be required to report abusive parents. And certain behaviors should be stigmatized—certainly none more so than child abuse. No one here today will dispute the devastating effects of severe alcohol and drug abuse during all stages of pregnancy. Assembly Bill 463 offers an effective mechanism for getting addicted mothers into treatment and preventing serious physical injury to their unborn children. Assembly Bill 463 does not punish these women. It provides them with the care and treatment they need and that they are too ill to seek for themselves."[139]

This protectionist language both evades the questions of invasion of personal autonomy linked to forcible physical confinement; it also assumes that women do not want treatment and that they cannot determine if and when they need it. Most importantly, it both reinforces and relies on the legitimacy of child welfare services' authority to intervene in parental behaviors, while largely removing authority (except for accepting reports and referring them to child welfare) from law enforcement. This reinforcement of child welfare authority is integrated into the mandated procedure for interventions in cases of substance-exposed infants. When a case is

---

[138] Testimony of Mary Klaver, representing Wisconsin Right to Life Inc., October 30, 1997, in the Committee Hearing Records of the Assembly Committee on Children and Families, Wisconsin, 1997-1998 session.

[139] Testimony of Representative Bonnie Ladwig, October 30, 1997, in the Committee Hearing Records of the Assembly Committee on Children and Families, Wisconsin, 1997-1998 session. Note that in my research, I did not find any arguments in the 1960s against expanding child maltreatment mandated reporting laws due to concerns that parents would not seek medical treatment for their children, though it is certainly possible that these claims were made.

reported, Wisconsin law gives county social workers or law enforcement officers (generally working with child welfare agencies) the right to take expectant mothers into custody. Places of custody can range from a relative's home to a drug treatment facility, a hospital, or a psychiatric ward, (but not a jail). This custody must be affirmed by a civil child welfare court, which has full jurisdiction over the "unborn child" of a substance-using pregnant woman (Wisconsin Statutes, Chapter 48: Children's Code).[140]

While those arguing in favor of the law did not specifically mention the infrastructural capacity of child welfare, they did not have to—it was already well established. Child welfare in Wisconsin had a decades-old jurisdictional legitimacy, enforced by a well-organized and relatively centralized infrastructure of agencies, funded by expanding federal funding since the 1960s. The language of the law, which passed on June 30, 1998, highlights not only the important role of child welfare, but a focus on risk reduction. The text reinforces a framing of substance-exposed infants as the paradigmatic example of a child at risk of future harm, thus justifying even severe surveillance that undermines women's bodily autonomy:

> Abuse means… any of the following: …When used in referring to an unborn child, serious physical harm inflicted on the unborn child, and the risk of serious physical harm to the child when born, caused by the habitual lack of self-control of the expectant mother of the unborn child in the use of alcohol beverages, controlled substance…" (Wisconsin Statutes, Chapter 48: Children's Code, section 48.02).

Implications of the law

The successful passage of AB 463 made Wisconsin one of five states with civil commitment statues applicable to pregnant women for the purposes of fetal protection. The language of the Wisconsin law is unusually severe in its attribution of blame to the pregnant woman, and its use of terms like "expectant mother" instead of pregnant woman and "unborn child" instead of fetus. Wisconsin's definition of "unborn child abuse" is limited to drug and alcohol use, and does not extend to other kinds of behavior, or to abuse by a third-party, such as a violent partner. Because this is a civil commitment process, the pregnant woman does not have full due process rights, and the case is automatically sealed because of confidentiality requirements.

As a result of this lack of transparency, data on implementation is uneven and relatively recent, but the available data indicates that, unlike other state civil commitment statutes, Wisconsin does appear to enforce the law. Wisconsin's annual child welfare reports began reporting "unborn child abuse" in 2005, the same year the electronic data collection system was first implemented state-wide. From 2005-2014, an average of 333 cases were reported every year, with substantiations ranging from 32% to 67%. Between eight and thirty newborns were taken away and placed in foster care annually, as shown in Table 6. These numbers represent those reported to child welfare, but not necessarily the total number of children born substance-exposed during this period. In terms of post-birth cases, an informational bulletin published by the Wisconsin Department of Health notes that the rate of maternal opioid use found among women delivering babies in Wisconsin hospitals has nearly tripled from 335 to 2009 to 1,041 in

[140] See specifically sections 48.19-20, 48.133, 48.193, 48.203, 48.205, 48.207, 48.213 of the Wisconsin Statutes, Chapter 48: Children's Code.

2014. They also note that about half of women who use opioids have babies with symptoms of neonatal abstinence syndrome (NAS), associated with opioid use.[141]

At least two cases have challenged Wisconsin's law on the civil commitment of pregnant women. The first, involving Alicia Beltran, a pregnant woman who was detained for involuntary drug treatment, was dismissed in 2014 on technical grounds (Beltran v. Strachota 2014). The second case involves Tamara Loertscher, a woman who was taking methamphetamine for severe depression associated with an untreated thyroid condition. She displayed no sign of addiction and immediately quit upon confirmation of her pregnancy, but she was detained in a hospital for several days, and then jailed for eighteen days for contempt of juvenile court because she refused to accept treatment and drug monitoring. Soon after her release, she found her fetus—and by extension herself—under the jurisdiction of her local county child welfare department. The case, which sought to overturn Act 292 as unconstitutional, eventually stalled, and the United States Supreme Court allowed the law to remain enforced while litigation continues. Act 292 continues in full force today in Wisconsin, with child welfare the primary authority over the fetuses of pregnant women reported for substance use (Loertscher v. Anderson 2018).[142]

Conclusion

By 1992, 22 states reported formal or informal policies mandating reporting of substance-exposed newborns to child welfare services and 4 states mandated reporting during pregnancy; by 1994, the number of states stating that they required SEI reporting had risen to 27 (McCurdy and Daro 1993: 19; Wiese and Daro 1995: 15). In 1997, two states (Wisconsin and South Dakota) passed civil commitment laws that allow child welfare services to commit pregnant substance-using women. By the early 2000s, state intervention in such cases was largely taken for granted in many states. In a demonstration of how regulatory power can works its way upwards, it was only in 2003, after many states passed these laws, that congress revised the Child Abuse Prevention and Treatment Act (CAPTA) to include mandatory reporting of substance-exposed infants to child welfare services for the first time. These revisions to CAPTA simply sanctioned what child welfare was already doing on the ground: intervening in cases of fetal substance exposure.

This chapter is the culmination of the story told in the first chapters of this dissertation. The case studies highlight how the infrastructural expansion and jurisdictional contraction that transformed child welfare into the child protective services of today enabled an expansion of regulatory authority that legitimized child welfare agencies as the primary regulators of perinatal interventions. The existence of a widespread infrastructure of child welfare agencies converged with their risk-focused protective authority, a framing that enabled legislators to legitimize an expansion of regulatory authority. Child welfare's protective authority rested on their coercive capacity to remove children, a form of punitive protection enabled by their expanded infrastructure, and one that both supporters and opponents of the bills discussed here saw as either useful or at least largely unproblematic. Both progressive legislators in California and

[141] Information is from a bulletin entitled "Neonatal Abstinence Syndrome (NAS) in Wisconsin," produced by Wisconsin Department of Health Services, Division of Mental Health and Substance Abuse Services P-01124 (October 2015). Note, however, that National Child Abuse and Neglect Data System (NCANDS), the national report on child abuse, shows that in 2015 Wisconsin reported only 2 "drug-dependent" infants, for a total of 0% of child abuse cases for infants under age one in the state. These different reports indicate inconsistent reporting around this issue. Unpublished data on reporting of substance-exposed infants was obtained directly from NCANDS.

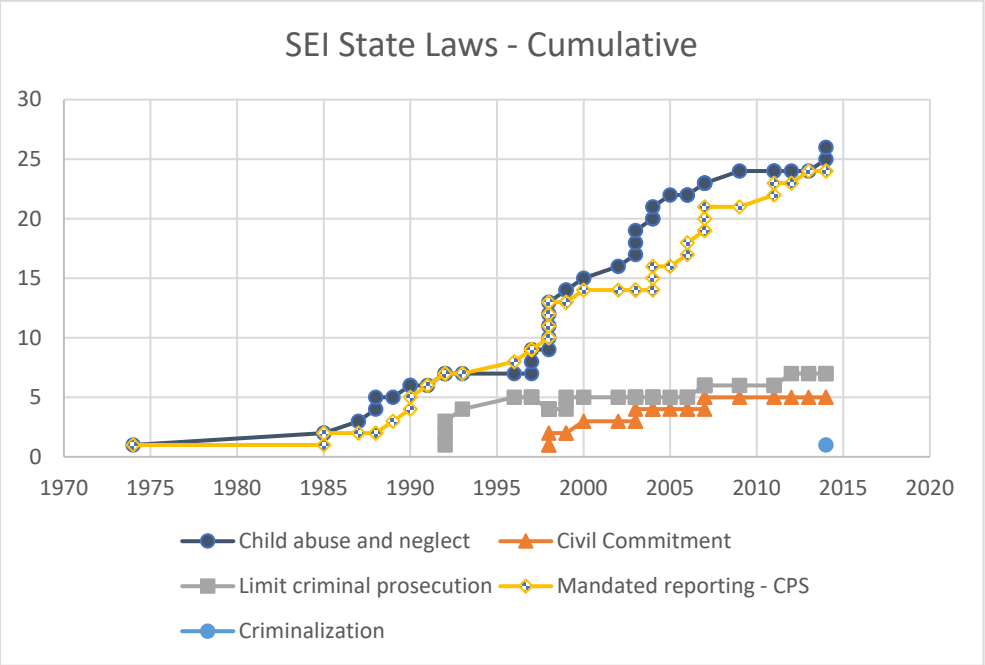
[142] Loertscher v. Anderson 2018.

conservative legislators in Wisconsin converged on this bipartisan legitimation of child welfare agencies' authority to regulate mothers and their children. Across the nation, state legislatures passed more than fifty laws reinforcing child welfare's legitimacy as the primary authorities to intervene not only in cases of risk to American children, but to engage in interventions that reached into the wombs of their mothers.

This chapter emphasizes the specifically civil—as opposed to criminal—regulation of SEI because it has important implications for the framing of expanded child welfare surveillance. Advocates from the 1980s until the present frame child welfare regulation as less punitive than criminal because it is a civil system, which does not involve jail time. Yet it is not entirely clear that it is. Some studies found a significant rise in infants in foster care during the 1980s and 1990s, an increase attributed to growing reports of cases of prenatal substance use (Haack 1997: 218-221; Sagatun-Edwards et al. 1995; USA 1990). Would mothers necessarily prefer to indefinitely lose custody of their child with little recourse and on the basis of relatively low evidence, instead of a limited prison term that at least in theory could only be applied on the basis of transparent and equal application of the law and a higher standard of evidence? Neither is a good option, especially considering that poor people often have weaker legal representation and worse outcomes in the criminal system as well, but claiming that jail is always the worse option can euphemize a system that separates families in ways that may be inconsistent and potentially deeply traumatizing.

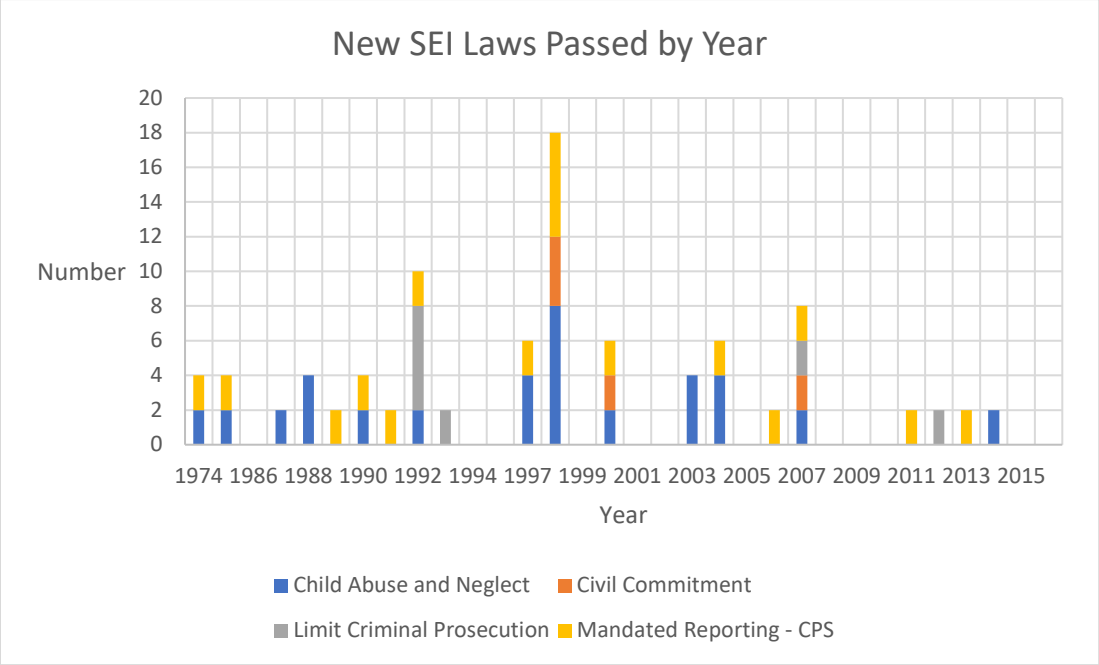
The expansion of child welfare's regulatory authority to include interventions in SEI represents the second juncture in which infrastructural expansion and jurisdictional legitimacy helped expand child welfare's regulatory authority. The first, described in chapter three, represented a shift from primarily law enforcement as the authority to respond to maltreatment reports to child welfare in the 1960s and 1970s. In that case, the massive prior infrastructural expansion of child welfare capacity—albeit for purposes that were primarily not maltreatment-focused—played an important role, and it was explicitly articulated by legal scholarship at that time (Paulsen 1966). In the second juncture, this shift also relied on the infrastructural capacity, and it was articulated indirectly by at least one advocate in California (see Cotta letter above). However, for the most part, legislators and advocates did not have to argue for the infrastructural capacity of child welfare agencies to intervene—it had already been established by the decades of infrastructural expansion, with growing funding and staffing for a widespread network of agencies spread across the nation, prepared for interventions in families. The expansion of child welfare's regulatory authority to intervene in SEI cases unfolded in a seemingly organic way in both California and Wisconsin—as well as in multiple state policies in the 1980s and 1990s, in laws passed by both liberal and conservative legislatures. This growth built on both child welfare's pre-existing capacity and its increasing focus on risk, with substance-exposed infants presented as the paradigmatic example of a child at risk, regardless of whether the child was actually harmed. The result was the expansion of child welfare's regulatory authority from interventions into cases of harm to the child, to risk of harm in the child's environment, including maternal prenatal behavior.

Figure 14: SEI State Laws



This chart tracks the cumulative number of laws in each category of SEI laws over time. Data from Sarah CM Roberts, Sue Thomas, and Ryan Treffers; supported by NIAAA R01 AA023267

Figure 15: SEI State Laws by Year



This chart tracks the yearly number of SEI laws passed from 1974-2014. Data from Sarah CM Roberts, Sue Thomas, and Ryan Treffers; supported by NIAAA R01 AA023267.

Table 6: Data on "Unborn Child Abuse" in Wisconsin 2005-2014

Year	Reports	Substantiated	Newborns removed
2005	303	49	10
2006	334	37	16
2007	352	51	30
2008	332	49	22
2009	314	48	10
2010	343	49	8
2011	312	35	11
2012	302	34	10
2013	347	48	16
2014	387	67	19

Data obtained from "Wisconsin Child Abuse and Neglect Report Appendices," 2007-2014, published by the Wisconsin Department of Children and Families. Reports of the same title containing this data for 2005-2006 were published by the Office of Program Evaluation and Planning, Division of Children and Family Services, Wisconsin Department of Health and Family Services.

CHAPTER 7. CONCLUSION

Introduction

This dissertation demonstrates how child welfare transformed from a sparsely staffed agency network broadly focused on multiple children's issues into a sprawling multi-billion-dollar system narrowly focused on child maltreatment. Integrating archival, legal, survey, and journal data, I argue that growing acceptance of child welfare protective authority (1950-1980) enabled legislators to expand regulation of substance-using pregnant women through funneling prenatal substance exposure into child welfare's jurisdiction (1980-2000). Existing scholarship links pregnancy surveillance to the criminalization of poverty, partisan anti-abortion advocacy, and medical authority. This chapter shows, however, that by the early 1990s, widespread opposition doomed criminalization efforts, and medical professionals took a back seat in interventions. Instead, throughout the 1990s, both liberal and conservative legislators harnessed child welfare's legitimacy as a protective authority over families, a bipartisan framing that obscured the fear of child removal underlying its power, to legislate interventions in substance-using mothers. Across five empirical chapters, the dissertation demonstrates that the rise of both child and fetal protectionism can be traced through the expansion of child welfare organizations that regulate this protection. Using historical and content analysis, the findings show that the existing scholarship overlooks the infrastructural expansion and jurisdictional shifts through which child welfare gained increasing legitimacy to assess risk and intervene in American families, enabling legislatures to use these agencies as an acceptable regulatory framing to implement perinatal protective policies.

This argument is supported by a new theoretical framework for regulatory authority, contributing to sociological literature that explores how authority expands and is legitimized in new social arenas. I argue that in order to explain how child welfare became a pervasive family regulation system in the United States in the second half of the twentieth century, especially for poor and minority families, we must examine its institutional development—specifically, how an expanding *infrastructural capacity* converged with a *contracting jurisdiction* to shape a regulatory authority that was simultaneously widely implemented and narrowly focused. By the 1980s, hundreds of agencies nationwide, initially funded and established for a wide range of child welfare issues in the 1950s and 1960s, now primarily intervened in cases of child maltreatment. This contraction was reinforced by an increasing focus on risk reduction, which acted as a funnel effect, channeling a growing number of factors, including perinatal behaviors, into child welfare's authority over American families. The interacting developments in jurisdiction and infrastructure were shaped by administrative logics that derived from broader welfare governance norms, including a shifting focus from rehabilitation of the poor to managerial efficiency, which had the effect of reducing rehabilitative services. These logics were in turn influenced by legislative advocacy and deeply rooted cultural schemas, including child protectionism, racial biases, and the questionable deservingness of poor Americans, which together shaped child welfare policy outcomes.

Empirical Findings

The dissertation argument outlined above, explicated at greater length in the dissertation introduction, is supported by five chapters of empirical data. Chapter 2 outlines a historical overview that establishes the historically fragmented nature of American welfare governance, which enabled the hybridization of regulatory governance, wherein state and professional actors

work in tandem to regulate American welfare. It also shows how specific cultural schemas of deservingness and child protectionism shaped the rise of organized efforts to advocate for children's welfare, culminating in the 1912 establishment of the Children's Bureau, an influential agency that set the agenda for child welfare until well into the 1960s. Finally, the origins of an individually-oriented casework method, and the evasion of racial inequality and poverty as central issues for child welfare, can be seen in the professionalization of social work, from which child welfare originated as a sub-specialty.

The third chapter demonstrates how child welfare shifted from a focus on providing comprehensive services to a specific population—children—to a focus on a specific problem—child maltreatment. In doing so, the chapter also shows how expanding infrastructural capacity, while intended for a wide range of problems, helped situate child welfare as the legitimate authority to respond to maltreatment specifically. However, instead of maltreatment remaining one of many issues child welfare actors addressed, it swelled to the primary issue, reinforced by broader welfare governance trends toward managerial efficiency, which reduced child welfare's resources for other problems and debilitated the Children's Bureau's authority to support a comprehensive rehabilitative model of child welfare among state agencies. The chapter also demonstrates how the expansion of infrastructural capacity and an extension of jurisdiction over urban areas translated into disproportionate interventions into minority families. The findings in this chapter map out the first of two key junctures in which infrastructural capacity and jurisdictional legitimacy interact to expand the regulatory authority of child welfare, specifically, the authority to intervene in growing reports of child maltreatment, disproportionately of poor and low-income families.

Chapters 4 and 5 explore how this expansion of child welfare's regulatory authority was linked to a specifically risk-focused paradigm of child maltreatment prevention. By the 1970s, the narrowed focus on child abuse and neglect, reinforced by mounting maltreatment reports and expanding resources focused on child removal, encouraged an increasing emphasis on developing instruments to assess the risk of maltreatment. Such instruments grew in popularity among child welfare agencies in the 1980s, in the hopes of reducing increasingly unmanageable caseloads and streamlining an inconsistent and complex process of processing reports. Chapter 4 shows how the development of such instruments reframed multiple family problems as risk factors for child maltreatment. Together with a growing surveillance system of mandated reporters, the growth of risk assessment as the primary mechanism of child maltreatment processing extended the reach of a jurisdictionally contracted child welfare system into disproportionately poor and minority families. Chapter 5 demonstrates that this focus on risk framed substance-exposed infants as paradigmatic cases of children at risk of future harm. The chapter findings reveals how medical professionals, the front-line workers to engage with substance-using women and their newborns, shied away from direct responsibility for intervention. In contrast, child welfare, both de facto and in professional discourses, saw the risks to substance-exposed infants—who were not necessarily directly harmed, but whose exposure to substances was correlated with potential later harms—as increasingly their responsibility.

Chapter 6, the final empirical chapter, shows how the combination of protective authority and the coercive power of child removal positioned child welfare as a legitimate professional network for state legislatures across political lines to authorize for interventions in substance-exposed infants. Supported by a detailed legislative analysis and two case studies of California and Wisconsin, respectively, I show that the most common policy outcome to legislative responses to the issue of substance-exposed infants (SEI) was child welfare authorization,

distantly followed by civil commitment. Both of these forms of civil regulation usually succeeded, while criminalization generally failed, and both empowered child welfare agencies with significant authority over mothers and children.

As the final empirical chapter, Chapter 6 maps out the second of the two key junctures in which infrastructural expansion, specifically a pre-existing infrastructure supported by expanding funding and staffing scattered across a fragmented American welfare state, coupled with the jurisdictional legitimacy of child welfare as a protective authority, enabled the expansion of regulatory authority. The first juncture, the expansion of child welfare regulatory authority over the growing issue of child maltreatment, was explained in Chapter 3. The second expansion unfolded through a funnel effect mechanism, in which a focus on risk reduction channeled women's prenatal behaviors into child welfare jurisdiction. Like the first juncture, other authorities—medical professionals and law enforcement—were considered by state legislatures as potential primary regulators of perinatal behavior, but in this second juncture, the legitimacy of child welfare's protective authority was largely undisputed. A now widespread infrastructure of far-flung child welfare agencies, supported by a multi-billion dollar state and federal budget, was already receiving mounting reports of substance-exposed infants, and new policies reinforced and institutionalized a de facto expanded regulatory authority of child welfare as the legitimate profession to intervene, as opposed to law enforcement or even medical professionals. For both of these junctures—the expansion of regulatory authority over child maltreatment and over substance-exposed infants—expansion did not mean growth in the classic sense. Instead, it indicated a funneling of a range of complex and multi-disciplinary issues into a contracted child welfare jurisdiction over the issue of child maltreatment.

Contributions to Knowledge

These findings make significant contributions to two empirical literatures on family regulation: child welfare and perinatal regulation. First, it contributes to knowledge about American child welfare by overturning the conventional narrative that child maltreatment was "discovered" in the 1950s and 1960s, primarily by medical doctors. With the exception of one footnote in a 1989 article on child welfare authority (Anderson 1989: n. 2), this narrative, first argued by Nelson (1984), is widely propagated across child welfare histories and practitioner handbooks, as well as medical and sociological research on child maltreatment (Association 2004; Costin et al. 1996; Hacking 1991; Lindsey 2004; Myers 2006; Raz 2020). The dissertation findings show that child maltreatment was an important issue throughout the 1940s and 1950s, but that it was not so much "rediscovered" as it ballooned in importance, even as other issues fell by the wayside. The dissertation's explanation for how this narrowing focus unfolded places child welfare in the broader ecology of American welfare state development. This goes beyond the current scholarship, which largely focuses on child welfare as an independent ecosystem, without recognizing the many ways—from a shift in focus on rehabilitation to managerial efficiency, and the systemic evasion of income and racial inequalities among American families—that it is deeply shaped by broader governance trends.

` The second literature in which this dissertation intervenes is the sociolegal scholarship on the perinatal regulation. Most of this literature, as noted above, focuses on the criminalization of pregnancy, as linked to both an increasingly punitive carceral state in the 1980s and to anti-abortion advocacy, as well as the role of medical authority. Yet the findings show that the current literature on women's reproductive autonomy overlooks an important element of the development of perinatal protective policies: the role of institutions in developing an intertwined

set of normative discourses and policy practices around child and fetal protectionism. Fetal protectionism developed in an era of increasingly complex organizations dedicated to child protection. Socio-legal work on fetal protection policies, however, tends to select on the dependent variable, seeking out cases with negative legal outcomes, such as arrests, civil detentions, or forced medical interventions, and then tracing it to the laws and ideologically motivated legislators, legislators, and judges that implemented them (Daniels 1996; Fentiman 2017a; Lewis 2016; Paltrow and Flavin 2013). This focus obscures the fact that the most drastic changes are not, in fact, to criminal laws, but to civil laws empowering child welfare services (Paltrow et al. 2000). The criminal system is usually not the primary arbiter of this issue; civilian child welfare agencies are, as are the public and private medical, non-profit, and professional organizations that work with and for them. The outsized role of civilian professionals in the regulation of both families and of women's pregnancies is a demonstration of the deeply-rooted hybrid nature of social welfare governance in the United States. Focusing on these non-state actors allows us to investigate civil and seemingly less invasive, but in fact more pervasive, forms of surveillance of women's bodies and women's mothering. These forms of surveillance result from the institutionalization of child welfare's authority to enforce specific protectionist schemas that are focused on risk reduction and that promote particular ways of valuing and caring for children, infants, and by extension, fetuses.

These forms of surveillance and their consequences vary by class, which often means by race as well. For many lower-income women, often women of color, this could mean that their newborns are taken away from them when state or medical personnel deem their parenting inadequate (Roberts 1997, 2002). For middle class women who face fewer challenges with childrearing resources and have far less interaction with the surveillance more typical of state welfare agencies and public hospitals (Bridges 2011), state intervention is more of an imagined threat than an actual danger, with peer circles of surveillance enforcing compliance with intensifying standards of childcare (Besharov 2000; Finkelhor and Jones 2006; Reich 2005), accompanied by high levels of parenting anxieties (Armstrong 2003; Stearns 2004). These anxieties are an inherent part of childrearing in a society that simultaneously sees children as real people with legal rights and is also increasingly focused on reducing risks and protecting children (Fass and Grossberg 2011; Grossberg 2003), a focus reinforced by the real power of child welfare agencies to intervene and remove children.

The transformation of child welfare from an underfunded and understaffed network of agencies to one that is deeply present in the lives of many families parallels the growth of fetal protection policies assigned to child welfare agencies. The dissertation indicates that the particularly complex position of child welfare—its power over poor women and its cultural resonance with middle class women and their parenting anxieties—plays a central role in institutionalizing notions of fetal personhood, with consequences that vary by class and region.[143] The result is a powerful state-professional hybrid of broad regulatory powers over American families today, who live at a bull's eye of a vast web of regulations regarding childcare.

This dissertation illuminates how regulatory authority over families has evolved over time, shaped by pre-existing American governance norms and capacity. Pre-existing structures include the American federalist polity, the fragmented nature of social welfare governance, and

[143] The 1974 passage of the Child Abuse Prevention and Treatment Act (CAPTA), the first federal legislation related to child maltreatment, was, in fact, promoted and passed on the basis of the idea that child abuse is a problem that is not related to class or race, and that middle class (i.e., white) women are just as likely to abuse their children (Nelson 1984).

its heavy reliance on the meso-level institutions that implement federal and state policy. Attempts at standardizing organizational responses to child welfare needs led to a mid-century growth of infrastructural capacity that converged with changes in jurisdiction, which first expanded and then narrowed to focus primarily on maltreatment. The role of infrastructure in shaping these policy outcomes is one of the key contributions of this dissertation. While speculating about what did not happen is difficult and questionably useful, it is possible that strong public outrage may have helped construct, ex nihilo, the child welfare resources required to respond to the skyrocketing number of child maltreatment reports in the 1970s. However, this seems unlikely. The original Children's Bureau model statues for mandatory reporting of maltreatment authorized police as the primary authority, and it would likely have remained that way if law enforcement was the only professional authority with the capacity to respond to reports. Maltreatment reports from an expanding number of mandated reporters motivated an increase in resources for maltreatment responses, and even these resources were relatively slow in coming. The first large infusion of federal funding devoted to child maltreatment arrived only in 1980 (through the Adoption Assistance and Child Welfare Act, P.L. 96-272), eighteen years after "The Battered Child Syndrome" (Kempe et al. 1962) was published. A more illustrative analogy might be to examine how nineteenth century outrage over child maltreatment helped spur the founding of hundreds of societies for the protection of children. Yet without state-sanctioned organizational infrastructure and jurisdictional legitimacy, these organizations disintegrated when public attention and state resources were diverted to other issues.

The history of child and fetal protectionism demonstrates that the infrastructural capacity and legitimacy of the meso-level professional organizations, supported by broader administrative logics and legislative advocacy, significantly shape national social policy outcomes. This is indicated not only by the professionalization and expansion of child welfare in the 1950s-1970s, but also by a wide range of welfare governance shifts throughout American history. State- and local-level charity boards and relief programs preceded federal programs, a combination of an expanding infrastructure and growing state-level child abuse reporting laws preceded the passage of federal child protection legislation, and state-level fetal protection policies preceded federal legislation of the same issue. In all these changes, a hybrid of professional and local- and state-level government actors gradually established an infrastructure and a set of policy norms, which in turn made broader national institutionalization of these policies possible. This dissertation establishes that long-lasting social policy—in this case, the expanding regulation of the private sphere of the family—relies on the availability of the infrastructure to implement it and builds on the pre-existing legitimacy of political and professional norms.

Implications for Further Research

The theoretical insights generated by this dissertation can be applied to further research in other realms of social governance. Despite extensive empirical research, there is little in the way of a comprehensive theoretical framework that explains jurisdictional contractions in the development of the American carceral system, where broad, liberal programs to address multiple issues of juvenile delinquency became ways to funnel marginalized youth into prison (Hinton 2016; Murakawa 2014). Similarly, the literature on the "carceral turn" in the American welfare state documents how American welfare became far more punitive, but it does not provide a clear explanation for why shifts across multiple arenas of welfare governance reshaped what were intended as supportive programs into punitive regulatory systems (Kohler-Hausmann 2015; Soss, Fording, and Schram 2011). Both of these phenomena can be partially explained by the extensive

literature on how policy feedback cycles lead to unintended consequences that reshape policy outcomes. Yet this dissertation's framing of regulatory authority goes beyond current literature to specify particular mechanisms by which an infrastructure constructed for one purpose can be reoriented to another. These mechanisms include the interaction between infrastructural expansion and the (much less studied process of) jurisdictional contraction, as well as how mechanisms for the "funnel effect" of jurisdictional contraction—whether by risk regulation tools or other instruments of surveillance—transform structural inequalities into individual inadequacies.

This research can also expand on the role of risk regulation, beyond the findings of this dissertation. Risk became a key construct across multiple disciplines in the 1980s and 1990s. Scholars of culture and anthropology during this period traced how risk is constructed culturally and by individuals (Beck 1992; Douglas and Wildavsky 1983). Criminologists focused on both assessing the actors most at risk for committing crimes and finding ways to mitigate the risks such actors pose for society. Scholars of law focused on how risk mitigation of dangerous populations (i.e., poor and minority groups) replaced rehabilitation as the chief goal of penal systems in the U.S. during the 1980s (Feeley and Simon 1992; Moore et al. 1985).

This dissertation charts another case of risk as a master frame, which, like the shift in criminology to risk of crime and its mitigation, is tied to pathologizing poor populations of color. Additional research can compare the historical development of risk as a master frame in the field of social work, and child welfare in particular, to the field of corrections, building on an analysis of historical risk instruments, archival research, and professional discourse analysis. The data analysis would focus on the following questions: How and why did risk arise as a master frame in each field? How was risk used in each field? What were the consequences to each field and to the people (i.e. "criminals" and "clients") managed by the professionals in each field?

In addition to broader multi-disciplinary work, new research can also expand on the questions that are the focus of this dissertation, specifically how regulation of women and families shifted and involved multiple civil authorities. This can be accomplished by adding additional case studies, especially of criminalization of substance-using pregnant women, and further study of the development of medical authority in regard to pregnancy and post-partum interventions across multiple problems. Finally, this dissertation focuses on a specifically American story of child welfare institutionalization. The findings and theory can be more rigorously examined and tested in context of an international comparison with both similar and different countries that developed family regulation systems in the twentieth century.

A broader focus on risk and on family regulation brings together the larger questions of how welfare regulation evolves, and what that means for our understanding of how regulatory authority develops and is legitimized over new social arenas. This is the core question that the research in this manuscript addresses. The dissertation argues that the current literatures on both child welfare and perinatal regulations problematically isolate closely related shifts in American welfare governance. Yet the dissertation findings show that the regulation of pregnant women is conducted primarily by the very institutions that receive the least attention in this literature: child welfare organizations. Indeed, forty-two states claim that they have policies requiring reporting of SEI to child welfare, who have significant authority over removal decisions (GAO 2018). Yet the current literature sheds little light on how child welfare services became the primary designated authority for most state policies, and how it gained jurisdictional authority over families. This dissertation reveals a complex institutionalization process, demonstrating how child welfare services was reframed—through both internal professionalization efforts and

broader welfare governance shifts—as the primary authority for regulating American families, a process that reinforced a particular notion of child protection. These findings illuminate how the legitimation and institutionalization of child welfare as a regulatory authority over families not only disproportionately affects poor and minority women, but structures widespread public assumptions about risk, maternal norms, and the boundaries of state-sanctioned interventions.

/

REFERENCES

Abel, Ernest L. 1998. “Protecting Fetuses from Certain Harm.” *Politics and the Life Sciences* 17(2):113–17.

Abrahamson, Daniel N. 1998. “Amicus Curiae Brief: Cornelia Whitner v. The State of South Carolina.” *Hastings Women’s Law Journal* 9(2).

Abramovitz, Mimi. 1996. *Regulating the Lives of Women: Social Welfare Policy from Colonial Times to the Present*. Boston: South End Press.

Abrams, Douglas E., and Sarah H. Ramsey. 2003. *Children and the Law: Doctrine, Policy and Practice*. St. Paul, MN: West Publishing Co.

Adirim, Terry A., and Nandini Sen Gupta. 1991. “A National Survey of State Maternal and Newborn Drug Testing and Reporting Policies.” *Public Health Reports (1974-)* 106(3):292–96.

AHA. 1981. *National Analysis of Official Child Neglect and Abuse Reporting, 1979. DHHS Publication No. (OHOS) 81-30232*. Colorado: American Humane Association, in association with Social Systems Research and Evaluation Division, Denver Research Institute, University of Denver.

American Humane Association. 1999. *Twelfth National Roundtable on Child Protective Services Risk Assessment, Summary of Proceedings, July 8-10, 1998*.

American Public Welfare Association. 1969. “Statement Submitted to the Advisory Council on Public Welfare, San Francisco CA, August 12, 1965.” in *Cooperation and Conflict: Readings in American Federalism*, edited by D. S. Angelo, R. B. Carroll, D. J. Elazar, and E. L. Levine. Itasca, Ill.: Peacock.

Amnesty International. 2017. *Criminalizing Pregnancy: Policing Pregnant Women Who Use Drugs in the USA*. London UK: Amnesty International Ltd.

Anderson, Paul Gerard. 1989. “The Origin, Emergence, and Professional Recognition of Child Protection.” *Social Service Review* 63(2):222–44.

Anon. 1958. “What Can We Do for Migrant Children?” *Child Welfare* 37.

Anon. 1989. “Drugs and Babies and Politics.” *Sacramento Bee*, April 30.

Ards, Sheila D., Samuel L. Myers Jr, Allan Malkis, Erin Sugrue, and Li Zhou. 2003. “Racial Disproportionality in Reported and Substantiated Child Abuse and Neglect: An Examination of Systematic Bias.” *Children and Youth Services Review* 25(5–6):375–92.

Armstrong, Elizabeth M. 2003. *Conceiving Risk, Bearing Responsibility: Fetal Alcohol Syndrome & the Diagnosis of Moral Disorder*. JHU Press.

Arnold, Mildred. 1947. *Children’s Services in the Public Welfare Agency*. Washington, D.C.: Federal Security Agency, Social Security Administration, U.S. Children’s Bureau.

Association, American Humane. 2004. *Helping in Child Protective Services: A Competency-Based Casework Handbook*. Oxford University Press, USA.

Ayoub, Catherine, and Marion M. Jacewitz. 1982. "Families at Risk of Poor Parenting: A Descriptive Study of Sixty at Risk Families in a Model Prevention Program." *Child Abuse & Neglect* 6(4):413–22. doi: 10.1016/0145-2134(82)90085-0.

Azzi-Lessing, Lenette, and Lenore J. Olsen. 1996. "Substance Abuse—Affected Families in the Child Welfare System: New Challenges, New Alliances." *Social Work* 41(1):15–23.

Baird, Christopher, Dennis Wagner, and Theresa Healy. 1999. "Risk Assessment in Child Protective Services: Consensus and Actuarial Model Reliability." *Child Welfare* 78(6):723–48.

Barth, Richard P., Judy Wildfire, and Rebecca L. Green. 2006. "Placement Into Foster Care and the Interplay of Urbanicity, Child Behavior Problems, and Poverty." *American Journal of Orthopsychiatry* 76(3):358–66. doi: 10.1037/0002-9432.76.3.358.

Beck, Ulrich. 1992. *Risk Society: Towards a New Modernity*. London ; Newbury Park, Calif: SAGE Publications Ltd.

Becker, Howard S. 1970. "Field Work Evidence." Pp. 39–62 in *Sociological work: Method and substance*, edited by H. S. Becker. New Brunswick, NJ: Transaction Books.

Bell, Robert. 1985. "Professional Values and Organizational Decision Making." *Administration and Society* 17(1):21–60.

Bell, Winifred., and Elizabeth Wickenden. 1961. *Public Welfare, Time for a Change; Report*. New York: Project on Public Services for Families and Children, New York School of Social Work of Columbia University.

Bernstein, Nina. 2002. *The Lost Children of Wilder: The Epic Struggle to Change Foster Care*. New York: Vintage.

Bernstein, Rose. 1966. "Emergency Care of Children— Necessary Evil or Meaningful Child Welfare Service?" *Child Welfare*.

Berrick, Jill Duerr, and Daniel Heimpel. 2020. "How Federal Laws Pertaining to Foster Care Financing Shape Child Welfare Services." in *The Oxford Handbook of Children and the Law*, edited by J. Dwyer. Oxford University Press.

Berry, Mary Frances. 1993. *The Politics of Parenthood: Child Care, Women's Rights, and the Myth of the Good Mother*. Viking.

Besharov, Douglas J. 2000. "Child Abuse Realities: Over-Reporting and Poverty." *Virginia Journal of Social Policy & the Law* 8(1):165-204.

Billingsley, Andrew. 1972. *Children of the Storm: Black Children and American Child Welfare*. New York: Harcourt College Pub.

Billingsley, Andrew, and Jeanne Giovanannoni. 1970. "Child Neglect Among the Poor: A Study of Parental Adequacy In Families of Three Ethnic Groups." *Child Welfare* XLIX(4).

Boehm, Bernice. 1964. “The Community and the Social Agency Define Neglect.” *Child Welfare*.

Bonner, Mark H., and Jennifer A. Sheriff. 2012. “A Child Needs a Champion: Guardian Ad Litem Representation for Prenatal Children.” *William & Mary Journal of Women and the Law* 19:511–84.

Bourdieu, Pierre. 1991. *Language and Symbolic Power*. Cambridge: Harvard University Press.

Bridges, Khiara M. 2011. *Reproducing Race: An Ethnography of Pregnancy as a Site of Racialization*. Berkeley: University of California Press.

Brindis, C. D., Z. Clayson, and G. Berkowitz. 1997. “Options for Recovery: California’s Perinatal Projects.” *Journal of Psychoactive Drugs* 29(1):89–99. doi: 10.1080/02791072.1997.10400173.

Campbell, Nancy. 2000. *Using Women: Gender, Drug Policy, and Social Justice*. Psychology Press.

Canaday, Margot. 2009. *The Straight State: Sexuality and Citizenship in Twentieth-Century America*. Princeton, N.J: Princeton University Press.

Carson, Daniel C. 1987. “Bill Offered Based on Pamela Rae Stewart Baby Case.” *San Diego Union-Tribune*, March 7, A-3.

Carten, Alma J. 1996. “Mothers in Recovery: Rebuilding Families in the Aftermath of Addiction.” *Social Work* 41(2):214–23.

Chasnoff, Ira J., William J. Burns, Sidney H. Schnoll, and Kayreen A. Burns. 1985. “Cocaine Use in Pregnancy.” *New England Journal of Medicine* 313(11):666–69. doi: 10.1056/NEJM198509123131105.

Chasnoff, Ira J., Harvey J. Landress, and Mark E. Barrett. 1990. “The Prevalence of Illicit-Drug or Alcohol Use during Pregnancy and Discrepancies in Mandatory Reporting in Pinellas County, Florida.” *New England Journal of Medicine* 322(17):1202–6. doi: 10.1056/NEJM199004263221706.

Chavkin, Wendy. 1996. “Mandatory Treatment for Pregnant Substance Abusers: Irrelevant and Dangerous.” *Politics and the Life Sciences* 15(1):53–54.

Cherry, April L. 2007. “The Detention, Confinement, and Incarceration of Pregnant Women for the Benefit of Fetal Health.” *Columbia Journal of Gender and Law* 16:147–98.

Child Welfare, Information Gateway. 2019. *Parental Drug Use as Child Abuse*. Children’s Bureau.

Children’s Bureau. 1946. *Public Social Services to Children: A Decade of Progress - 1935-1945.* 1. Washington, D.C.

Children’s Bureau. 1949. *Trends and Developments in Public Child Welfare Services.* 4. Federal Security Agency, Social Security Administration, Children’s Bureau.

Children’s Bureau. 1950a. *Personnel in Public Child Welfare Programs 1950*. 7. Children’s Bureau, Federal Security Agency, Social Security Administration.

Children's Bureau. 1950b. *Services for Children: Three Programs of the Children's Bureau*.

Children's Bureau. 1955. *Children Receiving Casework Services: June 1952*. 27. U.S. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau.

Children's Bureau. 1966. *The Child Abuse Reporting Laws: A Tabular View.* Washington, D.C: U.S. Dept. of Health, Education and Welfare, Welfare Administration, Children's Bureau.

Children's Bureau. 1968. *Child Welfare Statistics 1967*. 92. Children's Bureau.

Children's Bureau. 2014. *The Child Abuse Prevention and Treatment Act: 40 Years of Safeguarding America's Children*. U.S. Department of Health and Human Services, Children's Bureau.

Children's Bureau. 2017. *Making and Screening Reports of Child Abuse and Neglect*.

Cicchinelli, Louis F. 1990. "Risk Assessment Models: CPS Agencies and Future Directions." in *CPS Risk Assessment Conference - From Research to Practice: Designing the Future of Child Protective Services*, edited by Vermont Division of Social Services, American Public Welfare Association, and American Association for Protecting Children. Burlington, Vt.: Vermont Division of Social Services, American Public Welfare Association, American Association for Protecting Children.

Clemens, Elisabeth. 2006. "Lineages of the Rube Goldberg State: Building and Blurring Public Programs, 1900-1940." in *Rethinking Political Institutions: The Art of the State*, edited by I. Shapiro, S. Skowronek, and D. Galvin. New York: NYU Press.

Clemens, Elisabeth S. 1993. "Organizational Repertoires and Institutional Change: Women's Groups and the Transformation of U.S. Politics, 1890-1920." *American Journal of Sociology* 98(4):755–98.

Cohen, Wilbur J., and Robert M. Ball. 1962. "Public Welfare Amendments of 1962 and Proposals for Health Insurance for the Aged." *Social Security Bulletin* (10):3–22.

Coll, Blanche D. 1995. *Safety Net: Welfare and Social Security, 1929-1979*. Rutgers University Press.

Conrad-Hiebner, Aislinn, and Edward Scanlon. 2015. "The Economic Conditions of Child Physical Abuse: A Call for a National Research, Policy, and Practice Agenda." *Families in Society* 96(1):59.

Coombes, Phylus, Maureen McCormack, Mary Chipley, and Beverly Archer. 1978. "The INCADEX Approach to Identifying Problems and Evaluating Impact in Child Protective Services." *Child Welfare* 47(1).

Costin, Lela B., Howard Jacob Karger, and David Stoesz. 1996. *The Politics of Child Abuse in America*. New York: Oxford University Press.

Courtney, Mark E., Richard P. Barth, Jill Duerr Berrick, Devon Brooks, and et al. 1996. "Race and Child Welfare Services: Past Research and Future Directions." *Child Welfare* 75(2):99–137.

Cradock, Gerald. 2014. "Who Owns Child Abuse?" *Social Sciences* 3(4):854–70. doi: 10.3390/socsci3040854.

C.S. 1982. "Book Reviews: The Social Context of Child Abuse and Neglect." *Child Welfare* 61(3).

CWLA. 1937. *Standards for Child Protective Organizations*. Child Welfare League of America.

Cytryn, Steven M. 2010. "What Went Wrong - Why Family Preservation Programs Failed to Achieve Their Potential Note." *Cardozo Journal of Law & Gender* 17(1):81–108.

Daniel, Jessica H., Eli H. Newberger, Robert B. Reed, and Milton Kotelchuck. 1978. "Child Abuse Screening: Implications of the Limited Predictive Power of Abuse Discriminants from a Controlled Family Study of Pediatric Social Illness." *Child Abuse & Neglect* 2(4):247–59. doi: 10.1016/0145-2134(78)90023-6.

Daniels, Cynthia R. 1996. *At Women's Expense: State Power and the Politics of Fetal Rights*. Harvard University Press.

Daro, Deborah, and Karen McCurdy. 1991. *Current Trends in Child Abuse Reporting and Fatalities: The Results of the 1990 Annual Fifty State Survey.* The National Center on Child Abuse Prevention Research. a program of the National Committee for Prevention of Child Abuse.

Daro, Deborah, and Leslie Mitchel. 1989. *Child Abuse Fatalities Continue To Rise: The Results of the 1988 Annual Fifty State Survey*. The Center on Child Abuse Prevention Research, a program of the National Committee to Prevent Child Abuse.

Daro, Deborah, and Leslie Mitchel. 1990. *Current Trends in Child Abuse Reporting and Fatalities: The Results of the 1989 Annual Fifty State Survey*. The Center on Child Abuse Prevention Research, a program of the National Committee to Prevent Child Abuse.

De Francis, Vincent. 1956. *Child Protective Services in the United States, Reporting a Nationwide Survey.* Denver: American Humane Association.

De Francis, Vincent. 1967. *Child Protective Services: A National Survey*.

De Francis, Vincent, and Carroll L. Lucht. 1974. *Child Abuse Legislation in the 1970's,*. Denver: American Humane Association, Children's Division.

DePanfilis, Diane, and Maria Scannapieco. 1994. "Assessing the Safety of Children at Risk of Maltreatment: Decision-Making Models." *Child Welfare* 73:229–45.

Derthick, Martha. 1975. *Uncontrollable Spending for Social Services Grants*. Brookings Institution.

Dettlaff, Alan J., and Reiko Boyd. 2020. "Racial Disproportionality and Disparities in the Child Welfare System: Why Do They Exist, and What Can Be Done to Address Them?" *The ANNALS of the American Academy of Political and Social Science* 692(1):253–74. doi: 10.1177/0002716220980329.

Dettlaff, Alan J., Stephanie L. Rivaux, Donald J. Baumann, John D. Fluke, Joan R. Rycraft, and Joyce James. 2011. "Disentangling Substantiation: The Influence of Race, Income, and Risk on the Substantiation Decision in Child Welfare." *Children and Youth Services Review* 33(9):1630–37. doi: 10.1016/j.childyouth.2011.04.005.

DHEW. 1972. *Children Served by Public Welfare Agencies and Voluntary Child Welfare Agencies and Institutions.* U.S. Dept. of Health, Education, and Welfare, Social and Rehabilitation Service, Office of Information Systems, National Center for Social Statistics.

DHEW. 1975. *Social Services U.S.A.: Statistical Tables, Summaries & Analyses of Services Under Social Security Act Titles XX, IV-B & IV-C for Fifty States & D.C.* Washington, D.C.: U.S. Department of Health, Education, and Welfare, Social and Rehabilitation Service, National Center for Social Statistics.

DHEW, and AHA. 1979. *National Analysis of Official Child Abuse and Neglect Reporting, 1977*. DHEW Publication No. (OHDS) 79-30232. U.S. Department of Health, Education, and Welfare, Office of Human Development Services, Administration for Children, Youth and Families, Children's Bureau, National Center on Child Abuse and Neglect.

DiLeonardi, Joan W. 1980. "Decision Making in Protective Services." *Child Welfare* 59(6).

Dolan, Maura. 1994. "Assault Causing Miscarriage Can Be Murder Case." *Los Angeles Times*, May 17, OCA1.

Dore, Martha Morrison, Joan M. Doris, and Pearl Wright. 1995a. "Identifying Substance Abuse in Maltreating Families: A Child Welfare Challenge." *Child Abuse & Neglect* 19(5):531–43. doi: 10.1016/0145-2134(95)00013-X.

Dore, Martha Morrison, Joan M. Doris, and Pearl Wright. 1995b. "Identifying Substance Abuse in Maltreating Families: A Child Welfare Challenge." *Child Abuse & Neglect* 19(5):531–43. doi: 10.1016/0145-2134(95)00013-X.

Dore, Martha Morrison, Joan M Doris, and Pearl Wright. 1995. "Identifying Substance Abuse in Maltreating Families: A Child Welfare Challenge." *Child Abuse and Neglect* 19(5):531–43.

Doueck, Howard J., Diana J. English, and Diane DePanfilis. 1993. "Decision-Making in Child Protective Services: A Comparison of Selected Risk-Assessment Systems." *Child Welfare* 72:441–52.

Douglas, Mary, and Aaron Wildavsky. 1983. *Risk and Culture: An Essay on the Selection of Technological and Environmental Dangers*.

Downs, Susan W. 1990. "The Key Role of the Diffusion Agent in Introducing a Risk Assessment Instrument to Public Child Welfare Agency Staff." in *CPS Risk Assessment Conference - From Research to Practice: Designing the Future of Child Protective Services*, edited by Vermont Division of Social Services, American Public Welfare Association, and American Association for Protecting Children. Burlington, Vt.: Vermont Division of Social Services, American Public Welfare Association, American Association for Protecting Children.

Drake, B., and S. Zuravin. 1998. "Bias in Child Maltreatment Reporting: Revisiting the Myth of Classlessness." *The American Journal of Orthopsychiatry* 68(2):295–304.

Drake, Brett, Jennifer M. Jolley, Paul Lanier, John Fluke, Richard P. Barth, and Melissa Jonson-Reid. 2011. "Racial Bias in Child Protection? A Comparison of Competing Explanations Using National Data." *Pediatrics* 127(3):471–78. doi: 10.1542/peds.2010-1710.

Drake, Brett, and Melissa Jonson-Reid. 2011. "NIS Interpretations: Race and the National Incidence Studies of Child Abuse and Neglect." *Children and Youth Services Review* 33(1):16–20. doi: 10.1016/j.childyouth.2010.08.006.

Drake, Brett, Sang Moo Lee, and Melissa Jonson-Reid. 2009. "Race and Child Maltreatment Reporting: Are Blacks Overrepresented?" *Children and Youth Services Review* 31(3):309–16. doi: 10.1016/j.childyouth.2008.08.004.

Dubow, Sara. 2010. *Ourselves Unborn: A History of the Fetus in Modern America*. Oxford ; New York: Oxford University Press.

Dukette, Rita. 1978. *Structured Assessment: A Decision-Making Guide for Child Welfare* . Dept. of Health, Education, and Welfare, Office of Human Development Service, Chicago IL, Region V.

E.E.G. 1964. "Antipoverty - Editor's Page." *Child Welfare*.

Ehrenreich, John H. 1985. *The Altruistic Imagination: A History of Social Work and Social Policy in the United States*. Cornell University Press.

Elmer, Elizabeth. 1967. *Children in Jeopardy: A Study of Abused Minors and Their Families.* Pittsburgh: University of Pittsburgh Press.

Escaravage, Jody Hearn. 2014. "Child Maltreatment Entrenched by Poverty: How Financial Need Is Linked to Poorer Outcomes in Family Preservation." *Child Welfare* 93(1):79–98.

Ewick, Patricia, and Susan S. Silbey. 1998. *The Common Place of Law: Stories from Everyday Life*. Chicago: University of Chicago Press.

Families, Administration on Children, Youth and, The Children's Bureau, Administration for Children and Families, and U. S. Department of Health and Human Services. 2013. *The Children's Bureau Legacy: Ensuring the Right to Childhood*. Government Printing Office.

Fass, Paula S., and Michael Grossberg. 2011. *Reinventing Childhood After World War II*. University of Pennsylvania Press.

Feeley, Malcolm M., and Jonathan Simon. 1992. "The New Penology: Notes on the Emerging Strategy of Corrections and Its Implications." *Criminology* 30(4):449–74. doi: 10.1111/j.1745-9125.1992.tb01112.x.

Feig, Laura. 1990. *Drug Exposed Infants and Children: Service Needs and Policy Questions*. U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, Office of Human Services Policy, Division of Children and Youth Policy.

Feller Nusbaum, Janet, Howard A. Davidson, Mark Hardin, and Robert M. Horowitz. 1992. *Working With the Courts in Child Protection*. US Department of Health and Human Services, Administration on Children, Youth and Families, National Center on Child Abuse and Neglect.

Fentiman, Linda C. 2006. "The New 'Fetal Protection': The Wrong Answer to the Crisis of Inadequate Health Care for Women and Children." *Denver University Law Review* 84(2):537–99.

Fentiman, Linda C. 2017a. *Blaming Mothers: American Law and the Risks to Children's Health*. NYU Press.

Fentiman, Linda C. 2017b. “Doctors and Nurses Are Increasingly Helping Criminalize Pregnant Women and Mothers.” *From The Square*. Retrieved June 4, 2021 (https://www.fromthesquare.org/doctors-criminalize-mothers/).

Ferree, Myra Marx. 2003. “Resonance and Radicalism: Feminist Framing in the Abortion Debates of the United States and Germany.” *American Journal of Sociology* 109(2):304–44. doi: 10.1086/378343.

Finkelhor, David, and Lisa Jones. 2006. “Why Have Child Maltreatment and Child Victimization Declined.” *Journal of Social Issues* 685–716.

Finnegan, Loretta P., Susan M. Oehlberg, Dianne O’Malley Regan, and Martha E. Rudrauff. 1981. “Evaluation of Parenting, Depression and Violence Profiles in Methadone Maintained Women.” *Child Abuse & Neglect* 5(3):267–73. doi: 10.1016/0145-2134(81)90009-0.

Fluke, John D., Ying-Ying T. Yuan, John Hedderson, and Patrick A. Curtis. 2003. “Disproportionate Representation of Race and Ethnicity in Child Maltreatment: Investigation and Victimization.” *Children and Youth Services Review* 25(5–6):359–73.

Fong, Kelley. 2020. “Getting Eyes in the Home: Child Protective Services Investigations and State Surveillance of Family Life.” *American Sociological Review* 85(4):610–38. doi: 10.1177/0003122420938460.

Foucault, Michel, Graham Burchell, Colin Gordon, and Peter Miller. 1991. *The Foucault Effect: Studies in Governmentality : With Two Lectures by and an Interview with Michel Foucault*. Chicago: University of Chicago Press.

Frame, Laura. 1999. “Suitable Homes Revisited: An Historical Look at Child Protection and Welfare Reform.” *Children and Youth Services Review* 21(9):719–54. doi: 10.1016/S0190-7409(99)00052-3.

Franklin, Sarah. 1991. “Fetal Fascinations: New Dimensions to the Medical-Scientific Construction of Fetal Personhood.” Pp. 190–205 in *Off-Centre: Feminism and Cultural Studies*, edited by S. Franklin, C. Lury, and J. Stacey. Harpercollins Academic.

Freundlich, Madelyn, and Kathy Barbell. 2001. *Foster Care Today*. Washington, DC: Casey Family Programs.

FSAA. 1971. “A Family Service Replies to a United Fund.” *Family Service Highlights* 32(4).

Gainsborough, Juliet F. 2010. *Scandalous Politics: Child Welfare Policy in the States*. Washington, D.C: Georgetown University Press.

Gane, E. Marguerite. 1940. “A Decade of Child Protection.” *Annals of the American Academy of Political and Social Science* 212.

GAO, United States Government Accountability Office. 2018. *Substance-Affected Infants*. *GAO*. GAO-18-196.

Gelles, Richard J. 1975. “The Social Construction of Child Abuse.” *American Journal of Orthopsychiatry*.

Gideon, Koren, Pastuszak Anne, and Ito Shinya. 1998. “Drugs in Pregnancy.” *The New England Journal of Medicine* 10.

Gil, David G. 1970. *Violence Against Children: Physical Child Abuse in the United States*. Harvard University Press.

Gilbert, Neil. 1977. “The Transformation of Social Services.” *Social Service Review* 51(4):624–41. doi: 10.1086/643557.

Gomez, Laura E. 1994. “Processing and Managing Social Problems: The Institutionalization of Pregnant Women’s Drug Use in the California Legislature and Criminal Justice System.” PhD Dissertation, Department of Sociology, Stanford University.

Gomez, Laura E. 1997. *Misconceiving Mothers: Legislators, Prosecutors, and the Politics of Prenatal Drug Exposure*. Temple University Press.

Gray, Jane, Christy A. Cutler, Janet G. Dean, and C. H. Kempe. 1976. “Perinatal Assessment of Mother-Baby Interaction Christy Cutler, Janet Dean, C. Henry Kempe The.” in *Child Abuse and Neglect: The Family and the Community*, edited by R. E. Helfer and C. Henry Kempe. Cambridge MA: Ballinger Publishing Company.

Gray, Jane D., Christy A. Cutler, Janet G. Dean, and C. Henry Kempe. 1977. “Prediction and Prevention of Child Abuse and Neglect.” *Child Abuse & Neglect* 1(1):45–58. doi: 10.1016/0145-2134(77)90046-1.

Gray, Jane D., Christy A. Cutler, Janet G. Dean, and C. Henry Kempe. 1979. “Prediction and Prevention of Child Abuse and Neglect.” *Journal of Social Issues* 35(2):127–39. doi: 10.1111/j.1540-4560.1979.tb00805.x.

Green, Rob, Shelley Waters Boots, and Karen C. Tumlin. 1999. *The Cost of Protecting Vulnerable Children: Understanding Federal, State, and Local Child Welfare Spending*. *Occasional Paper*. 20. Urban Institute.

Grossberg, Michael. 2003. “A Protected Childhood: The Emergence of Child Protection in America.” in *American Public Life and the Historical Imagination*, edited by W. Gamber, M. Grossberg, and H. Hartog. University of Notre Dame Press.

Gustavsson, Nora S. 1991. “The War Metaphor: A Threat to Vulnerable Populations.” *Social Work* 36(4):277–78.

Haack, Mary R. 1997. *Drug-Dependent Mothers and Their Children: Issues in Public Policy and Public Health*. Springer Publishing.

Hacking, Ian. 1991. “The Making and Molding of Child Abuse.” *Critical Inquiry* 17(2):253–88.

Hager, Philip. 1992a. “Case against Mother May Limit Fetal Murder Trials.” *Los Angeles Times*, June 17, OCA3.

Hager, Philip. 1992b. “Murder Charge Is Rejected in Drug-Related Stillbirth.” *Los Angeles Times*, August 22, OCA13.

Halpern, Robert, 1951-. 1986. “Home-Based Early Intervention: Dimensions of Current Practice.” *Child Welfare* 65:387–98.

Helfer, Ray E. 1976. “Basic Issues Concerning Prediction.” in *Child Abuse and Neglect: The Family and the Community*. Cambridge MA: Ballinger Publishing Company.

Hinton, Elizabeth. 2016. *From the War on Poverty to the War on Crime: The Making of Mass Incarceration in America*. 1 edition. Cambridge, Massachusetts: Harvard University Press.

Holzschuh, Alma. 1938. *Census of Social Workers in California, 1938*. San Francisco: Board of Examiners, Department of Registration and Certification, California Conference of Social Work.

Howard, Grace Elizabeth. 2017. “The Criminalization of Pregnancy: Rights, Discretion, and the Law.” PhD Dissertation, Department of Political Science, Rutgers, The State University of New Jersey, New Jersey.

Hughes, Ronald C., and Judith S. Rycusa. 2006. “Issues in Risk Assessment in Child Protective Services.” *Journal of Public Child Welfare* 1(1):85–116. doi: 10.1300/J479v01n01_05.

Humphries, Drew. 1999. *Crack Mothers: Pregnancy, Drugs, and the Media*. Ohio State University Press.

Hutchinson, Emily T. 1987. “The Level of Risk Scale in Child Protective Services.” in *A Summary of the Highlights of the National Roundtable on CPS Risk Assessment and Family Systems Assessment: April 30 and May 1, 1987, San Francisco, California*, edited by T. Tatara. Washington, D.C.: American Public Welfare Association, Family Based Service Project.

Hutchinson, Janet R. 2002. *Failed Child Welfare Policy: Family Preservation and the Orphaning of Child Welfare*. University Press of America.

Jaudes, Paula Kienberger, Edem Ekwo, and John Van Voorhis. 1995. “Association of Drug Abuse and Child Abuse.” *Child Abuse & Neglect* 19(9):1065–75. doi: 10.1016/0145-2134(95)00068-J.

Jeter, Helen Rankin. 1960. *Children Who Receive Services from Public Child Welfare Agencies*. DHEW, SSA, CB.

Jeter, Helen Rankin. 1962. *Services in Public and Voluntary Child Welfare Programs*. U.S. Department of Health, Education and Welfare Social Security Administration, Children’s Bureau.

Jeter, Helen Rankin. 1963. *Children, Problems, and Services in Child Welfare Programs*. U. S. Department of Health, Education, and Welfare, Welfare Administration, Children’s Bureau.

Jimenez, Jillian. 2006. “The History of Child Protection in the African American Community: Implications for Current Child Welfare Policies.” *Children and Youth Services Review* 28(8):888–905. doi: 10.1016/j.childyouth.2005.10.004.

Johnson, Genevieve M. 1950. “Significant Considerations in Placing Negro Infants for Adoption.” *Child Welfare*.

Johnson, Will. 1987. “Predicting Recurrence of Physical Abuse in Pre-Placement Preventive Services.” in *A Summary of the Highlights of the National Roundtable on CPS Risk Assessment and Family*

Systems Assessment: April 30 and May 1, 1987, San Francisco, California, edited by T. Tatara. Washington, D.C.: American Public Welfare Association, Family Based Service Project.

Jones, Mary Ann. 1988. "Book Review: Unattended Children." 67(2).

Jonquet, Eugene. 1956. "Some Negative Aspects of Parent Education." *Child Welfare*.

Jonson-Reid, Melissa, Brett Drake, and Patricia L. Kohl. 2009. "Is the Overrepresentation of the Poor in Child Welfare Caseloads Due to Bias or Need?" *Children and Youth Services Review* 31(3):422–27. doi: 10.1016/j.childyouth.2008.09.009.

Katz, Michael B. 1996. *In the Shadow Of the Poorhouse: A Social History Of Welfare In America, Tenth Anniversary Edition*. Basic Books.

Katz, Michael B. 2013. *The Undeserving Poor: America's Enduring Confrontation with Poverty: Fully Updated and Revised*. Oxford: Oxford University Press.

Kaufman, Debra Renee. 1991. *Rachel's Daughters: Newly Orthodox Jewish Women*. New Brunswick: Rutgers University Press.

Kelley, Susan J. 1992. "Parenting Stress and Child Maltreatment in Drug-Exposed Children." *Child Abuse & Neglect* 16(3):317–28. doi: 10.1016/0145-2134(92)90042-P.

Kempe, C. H., Ray E. Helfer, Carol Schneider, James K. Hoffmeister, and Ray E. Helfer, eds. 1976. "A Predictive Screening Questionnaire for Potential Problems in Mother-Child Interaction." in *Child Abuse and Neglect: The Family and the Community*. Cambridge, Mass: Ballinger Pub. Co.

Kempe, C., Silverman FN, Steele BF, Droegemueller W, and Silver HK. 1962. "The Battered-Child Syndrome." *JAMA* 181(1):17–24. doi: 10.1001/jama.1962.03050270019004.

Kettner, Peter M., and John M. Daley. 1988. "Designing Effective Programs." *Child Welfare* 67(2).

Kim, Hyunil, Christopher Wildeman, Melissa Jonson-Reid, and Brett Drake. 2017. "Lifetime Prevalence of Investigating Child Maltreatment Among US Children." *American Journal of Public Health; Washington* 107(2):274–80.

Kinard, E. Milling. 1982. "Child Abuse and Depression; Cause or Consequence?" *Child Welfare* 61:403–13.

Koerin, Beverly B. 1980. "Child Abuse and Neglect: Changing Policies and Perspectives." *Child Welfare* 59(9).

Kohler-Hausmann, Julilly. 2015. "Guns and Butter: The Welfare State, the Carceral State, and the Politics of Exclusion in the Postwar United States." *Journal of American History* 102(1):87–99. doi: 10.1093/jahist/jav239.

Krugman, Richard D. 1985. "Neonatal Ethanol Withdrawal: Characteristics in Clinically Normal Non-Dysmorphic Neonates: Journal of Pediatrics105:445–451 (1984). Coles, C., Smith, I., Fernhoff, P. and Falek, A. Human and Behavioral Genetics Research Laboratory, Georgia Mental Health Institute, Atlanta. GA." *Child Abuse & Neglect* 9(4):581–82. doi: 10.1016/0145-2134(85)90075-4.

Kunzel, Regina G. 1995. *Fallen Women, Problem Girls: Unmarried Mothers and the Professionalization of Social Work, 1890-1945*. Yale University Press.

Ladd-Taylor, Molly. 1994. *Mother-Work: Women, Child Welfare, and the State, 1890-1930*. University of Illinois Press.

Lanier, Paul, Katie Maguire-Jack, Tova Walsh, Brett Drake, and Grace Hubel. 2014. "Race and Ethnic Differences in Early Childhood Maltreatment in the United States." *Journal of Developmental and Behavioral Pediatrics: JDBP* 35(7):419–26. doi: 10.1097/DBP.0000000000000083.

Laskey, Antoinette L., Timothy E. Stump, Susan M. Perkins, Gregory D. Zimet, Steven J. Sherman, and Stephen M. Downs. 2012. "Influence of Race and Socioeconomic Status on the Diagnosis of Child Abuse: A Randomized Study." *The Journal of Pediatrics* 160(6):1003-1008.e1. doi: 10.1016/j.jpeds.2011.11.042.

Lauderdale, Michael L., Rosalie N. Anderson, and Stephen Cramer, eds. 1978. "Child Abuse and Neglect : Issues on Innovation and Implementation - Proceedings of the Second Annual National Conference on Child Abuse and Neglect, April 17-20, 1977."

Lawder, Elizabeth A., John E. Poulin, and Roberta G. Andrews. 1985. "A Study of 185 Foster Children 5 Years After Placement." *Child Welfare* 65(3).

Lawrence-Webb, Claudia. 1997. "African American Children in the Modern Child Welfare System: A Legacy of the Flemming Rule." *Child Welfare* 76(1):9–30.

Lee, Konrad S., and Matthew I. Thue. 2009. "Unpacking the Package Theory: Why California's Statutory Scheme for Terminating Parental Rights in Dependent Child Proceedings Violates the Due Process Rights of Parents as Defined by the United States Supreme Court in Santosky v. Kramer." *UC Davis Journal of Juvenile Law & Policy* 13(1):143–200.

Leiby, James. 1978. *A History of Social Welfare and Social Work in the United States*. Columbia University Press.

Levin, Herman. 1968. "The Logic of Merging Public Services for Family and Child Welfare: Historical Support." *Child Welfare*.

Lewis, Myrisha S. 2016. "Criminalizing Substance Abuse and Undermining Roe v. Wade: The Tension between Abortion Doctrine and the Criminalization of Prenatal Substance Abuse." *William & Mary Journal of Women and the Law* 23:185–218.

Lichtenstein, Matty, and Zawadi Rucks-Ahidiana. 2020. "Contextual Text Coding: A Mixed Methods Approach for Large-Scale Textual Data." *Sociological Methods & Research*.

Lindenmeyer, Kriste. 1997. *A Right to Childhood: The U.S. Children's Bureau and Child Welfare, 1912-46*. Urbana: University of Illinois Press.

Lindesmith Center. N.D. "Research Brief: Cocaine & Pregnancy."

Lindsey, Duncan. 2004. *The Welfare of Children*. Oxford; New York: Oxford University Press.

Lobb, Michael L., and George Michael Strain. 1984. “Temporal Patterns of Child Abuse and Neglect Reporting: Implications for Personnel Scheduling.” *Child Welfare* 63(5).

Loewenstein, Sophie. 1973. “Special Report: Conclusion of a Study of PARI as a Research Tool.” *Child Welfare* 52(6).

Loveman, Mara. 2005. “The Modern State and the Primitive Accumulation of Symbolic Power.” *American Journal of Sociology* 110(6):1651–83. doi: 10.1086/ajs.2005.110.issue-6.

Lubove, Roy. 1965. *The Professional Altruist: The Emergence of Social Work as a Career, 1880-1930*. Harvard University Press.

Luker, Kristin. 1998. “Sex, Social Hygiene, and the State: The Double-Edged Sword of Social Reform.” *Theory and Society* 27(5):601–34.

Macallair, Daniel E. 2015. *After the Doors Were Locked: A History of Youth Corrections in California and the Origins of Twenty-First Century Reform*. Rowman & Littlefield.

Mann, Michael. 1984. “The Autonomous Power of the State: Its Origins, Mechanisms and Results.” *European Journal of Sociology / Archives Européennes de Sociologie* 25(02):185–213. doi: 10.1017/S0003975600004239.

Mann, Michael. 1993. *The Sources of Social Power, Vol. 2: The Rise of Classes and Nation States, 1760-1914*. Cambridge; New York: Cambridge University Press.

Mann, Michael. 2008. “Infrastructural Power Revisited.” *Studies in Comparative International Development* 43(3–4):355. doi: 10.1007/s12116-008-9027-7.

Marcenko, Maureen O., and Michael Spence. 1995. “Social and Psychological Correlates of Substance Abuse among Pregnant Women.” *Social Work Research* 19(2):103–9.

Mathieu, Deborah. 1995. “Mandating Treatment for Pregnant Substance Abusers: A Compromise.” *Politics and the Life Sciences* 14(2):199–208.

McCoid, Allan. 1965. “The Battered Child and Other Assaults upon the Family: Part One.” *Minnesota Law Review*.

McCurdy, Karen, and Deborah Daro. 1993. *Current Trends in Child Abuse Reporting and Fatalities: The Results of the 1992 Annual Fifty State Survey*. Chicago: National Center on Child Abuse Prevention Research, a program of the National Committee for Prevention of Child Abuse.

Mcdonald, Thomas, and Jill Marks. 1991. “A Review of Risk Factors Assessed in Child Protective Services.” *Social Services Review* 65(1):112–32.

McKay, Mary McKernan. 1994. “The Link between Domestic Violence and Child Abuse: Assessment and Treatment Considerations.” *Child Welfare* 73(1):29–39.

Michel, Sonya. 2013. “The Limits of Maternalism: Policies Toward American Wage-Earning Mothers During the Progressive Era.” in *Mothers of a New World*, edited by S. Michel and S. Koven.

Migdal, Joel S. 2001. *State in Society: Studying How States and Societies Transform and Constitute One Another*. Cambridge; New York: Cambridge University Press.

Miles, Rufus E. 1974. *The Department of Health, Education, and Welfare*. Praeger.

Miller, Pavla. 1998. *Transformations of Patriarchy in the West: 1500-1900*. Bloomington: Indiana University Press.

Milner, Joel S., and Catherine Ayoub. 1980. "Evaluation of 'At Risk' Parents Using the Child Abuse Potential Inventory." *Journal of Clinical Psychology* 36(4):945–48. doi: 10.1002/1097-4679(198010)36:4<945::AID-JCLP2270360420>3.0.CO;2-K.

Milner, Joel S., Ruth G. Gold, Catherine Ayoub, and Marion M. Jacewitz. 1984. "Predictive Validity of the Child Abuse Potential Inventory." *Journal of Consulting and Clinical Psychology* 52(5):879–84. doi: 10.1037/0022-006X.52.5.879.

Milner, Joel S., and Aonald C. Wimberley. 1980. "Prediction and Explanation of Child Abuse." *Journal of Clinical Psychology* 36(4):875–84. doi: 10.1002/1097-4679(198010)36:4<875::AID-JCLP2270360407>3.0.CO;2-1.

Milner, Joel S., and Ronald C. Wimberley. 1979. "An Inventory for the Identification of Child Abusers." *Journal of Clinical Psychology* 35(1):95–100. doi: 10.1002/1097-4679(197901)35:1<95::AID-JCLP2270350112>3.0.CO;2-K.

Mitchiner, Myra J. 1966. "Providing Preventive and Protective Services to Children in a Public Welfare Agency." *Child Welfare*.

Mittelstadt, Jennifer. 2005. *From Welfare to Workfare: The Unintended Consequences of Liberal Reform, 1945-1965*. University of North Carolina Press.

Moffitt, Robert A. 2015. "The Deserving Poor, the Family, and the U.S. Welfare System." *Demography* 52(3):729–49. doi: 10.1007/s13524-015-0395-0.

Mohapatra, Seema. 2011. "Unshackling Addiction: A Public Health Approach to Drug Use during Pregnancy." *Wisconsin Journal of Law, Gender & Society* 26:241–74.

Moore, Mark H., Susan Estrich, Daniel McGillis, and William Spelman. 1985. *Dangerous Offenders: The Elusive Target of Justice*.

Morgan, Kimberly J., and Andrea Louise Campbell. 2011. *The Delegated Welfare State: Medicare, Markets, and the Governance of Social Policy*. Oxford University Press.

Murakawa, Naomi. 2014. *The First Civil Right: How Liberals Built Prison America*. Oxford University Press.

Murphy, Andrew S. 2014. "A Survey of State Fetal Homicide Laws and Their Potential Applicability to Pregnant Women Who Harm Their Own Fetuses Comment." *Indiana Law Journal* 89:847–84.

Murray, Melissa, and Kristin Luker. 2014. *Cases on Reproductive Rights and Justice*. St. Paul, MN: Foundation Press.

Myers, John E. B. 1986. “A Survey of Child Abuse and Neglect Reporting Statutes.” *Journal of Juvenile Law* 10(1):1–72.

Myers, John E. B. 2006. *Child Protection in America: Past, Present, and Future*. Oxford ; New York: Oxford University Press.

Nair, Prasanna, Maureen M. Black, Maureen Schuler, Virginia Keane, Laurel Snow, Betty Ann Rigney, and Laurence Magder. 1997. “Risk Factors for Disruption in Primary Caregiving among Infants of Substance Abusing Women.” *Child Abuse & Neglect* 21(11):1039–51. doi: 10.1016/S0145-2134(97)00064-1.

Najdowski, Cynthia J., and Kimberly M. Bernstein. 2018. “Race, Social Class, and Child Abuse: Content and Strength of Medical Professionals’ Stereotypes.” *Child Abuse & Neglect* 86:217–22. doi: 10.1016/j.chiabu.2018.10.006.

NCCAN. 1977. *Proceedings of the First National Conference on Child Abuse and Neglect: January 4-7, 1976.* Washington, D.C.: National Center on Child Abuse and Neglect.

NCCAN. 1978. *Child Abuse and Neglect: Issues on Innovation and Implementation. Proceedings of the Second Annual National Conference on Child Abuse and Neglect, April 17-20, 1977*. Washington: National Center on Child Abuse and Neglect, Children’s Bureau, Administration for Children, Youth, and Families, Office of Human Development Services, U.S. Dept. of Health, Education, and Welfare.

NCCAN. 1979. *The Fourth National Conference on Child Abuse and Neglect*. Region IX Child Abuse & Neglect Resource Center, California State University, Los Angeles, California, in cooperation with the National Center on Child Abuse .& Neglect, Children’s Bureau, Administration for Children, Youth and Families, Department of Health, Education and Welfare, Washington, D.C.

Nelson, Barbara J. 1984. *Making an Issue of Child Abuse*. Chicago: University of Chicago Press.

Newgent, Frank. 1963. “Issues for Child Welfare in the 1962 Public Welfare Amendments.” *Child Welfare*.

Novak, William J. 2008. “The Myth of the ‘Weak’ American State.” *The American Historical Review* 113(3):752–72. doi: 10.1086/ahr.113.3.752.

Oliphant, Winford. 1974. “Observations on Administration of Social Services in the States.” *Child Welfare* 52(5).

Olmstead, Judy. 1989. “Considerations as We Evaluate Risk Assessment Models.” in *Research Issues in Risk Assessment for Child Protection*, edited by Kathern. Bond and Patricia. Schene. Denver, Colorado: American Association for Protecting Children.

Orren, Karen, and Stephen Skowronek. 2016. “Pathways to the Present.” *The Oxford Handbook of American Political Development*. doi: 10.1093/oxfordhb/9780199697915.013.19.

Ortiz, Aimee. 2019. “Mother Is Freed After 15 Years in Prison for Father’s Abuse.” *The New York Times*, November 8.

Ouellette, Eileen M., Henry L. Rosett, N. Paul Rosman, and Lyn Weiner. 1977. "Adverse Effects on Offspring of Maternal Alcohol Abuse during Pregnancy." *New England Journal of Medicine* 297(10):528–30. doi: 10.1056/NEJM197709082971003.

Paltrow, L., D. S. Cohen, and Corinne A. Carey. 2000. *Year 2000 Overview: Governmental Responses to Pregnant Women Who Use Alcohol or Other Drugs*. Women's Law Project & National Advocates for Pregnant Women.

Paltrow, Lynn M. 2013. "Roe v Wade and the New Jane Crow: Reproductive Rights in the Age of Mass Incarceration." *American Journal of Public Health* 103(1):17–21. doi: 10.2105/AJPH.2012.301104.

Paltrow, Lynn M., and Jeanne Flavin. 2013. "Arrests of and Forced Interventions on Pregnant Women in the United States, 1973-2005: Implications for Women's Legal Status and Public Health." *Journal of Health Politics, Policy and Law* 38(2):299–343. doi: 10.1215/03616878-1966324.

Patton, Michael Quinn. 2002. *Qualitative Evaluation and Research Methods*. 2nd ed. Thousand Oaks, CA: Sage Publications.

Paulsen, Monrad G. 1966. "The Legal Framework for Child Protection." *Columbia Law Review* 66(4):679–717. doi: 10.2307/1121022.

Paulsen, Monrad G. 1967a. "Child Abuse Reporting Laws: The Shape of the Legislation." *Columbia Law Review* 67(1):1–49. doi: 10.2307/1121129.

Paulsen, Monrad G. 1967b. "Child Abuse Reporting Laws: The Shape of the Legislation." *Columbia Law Review* 67(1):1–49. doi: 10.2307/1121129.

Pecora, Peter J. 1989. "Evaluating Risk Assessment Systems: Methodological Issues and Selected Research Findings." in *Research Issues in Risk Assessment for Child Protection*, edited by Kathern. Bond and Patricia. Schene. Denver, Colorado: American Association for Protecting Children.

Pecora, Peter J. 1991. "Investigating Allegations of Child Maltreatment:" *Child & Youth Services* 15(2):73–92. doi: 10.1300/J024v15n02_05.

Pelton, Leroy H. 1978. "Child Abuse and Neglect: The Myth of Classlessness." *American Journal of Orthopsychiatry* 48(4):608–17. doi: 10.1111/j.1939-0025.1978.tb02565.x.

Pelton, Leroy H. 1981. *The Social Context of Child Abuse and Neglect*. New York: Human Sciences Press.

Pelton, Leroy H. 1997. "Child Welfare Policy and Practice: The Myth of Family Preservation." *American Journal of Orthopsychiatry* 67(4):545–53.

Pelton, Leroy H. 2015a. "The Continuing Role of Material Factors in Child Maltreatment and Placement." *Child Abuse & Neglect* 41:30–39. doi: 10.1016/j.chiabu.2014.08.001.

Pelton, Leroy H. 2015b. "The Continuing Role of Material Factors in Child Maltreatment and Placement." *Child Abuse & Neglect* 41:30–39. doi: 10.1016/j.chiabu.2014.08.001.

Peretz, Paul, and Jean Reith Schroedel. 1996. “The Road Not to Travel: A Comment on Deborah Mathieu’s Proposal to Mandate Outpatient Treatment for Pregnant Substance Abusers.” *Politics and the Life Sciences* 15(1):67–69.

Phillips, Luke. 2017. “Nixon’s Revolutionary Vision for American Governance.” *Richard Nixon Foundation*. Retrieved June 28, 2020 (https://www.nixonfoundation.org/2017/01/nixons-vision-for-american-governance/).

Phillips, Michael H., Barbara H. Haring, and Ann W. Shyne. 1972. *A Model for Intake Decisions in Child Welfare*. Child Welfare League of America, Research Center.

Pierson, Paul. 2000. “Increasing Returns, Path Dependence, and the Study of Politics.” *The American Political Science Review* 94(2):251–67. doi: 10.2307/2586011.

Polansky, Norman A., Robert D. Borgman, Christine De Saix, and Betty J. Smith. 1970. “Two Modes of Maternal Immaturity and Their Consequences.” XLIX(6).

Polansky, Norman A., Mary Ann Chalmers, Elizabeth Buttenwieser, and David Williams. 1978. “Assessing Adequacy of Child Caring: An Urban Scale.” *Child Welfare* 57(7).

Polier, Judith Wise. 1976. “In Defense of Children.” *Child Welfare* 55(2).

Popple, Philip R. 2018. *Social Work Practice and Social Welfare Policy in the United States: A History*.

Pratt, Lisa. 2013. “Access to Vaginal Birth after Cesarean: Restrictive Policies and the Chilling of Women’s Medical Rights during Childbirth 2013 Special Issue: Reproductive Justice.” *William & Mary Journal of Women and the Law* 20:105–22.

Putnam-Hornstein, Emily, Barbara Needell, Bryn King, and Michelle Johnson-Motoyama. 2013. “Racial and Ethnic Disparities: A Population-Based Examination of Risk Factors for Involvement with Child Protective Services.” *Child Abuse & Neglect* 37(1):33. doi: 10.1016/j.chiabu.2012.08.005.

Putnam-Hornstein, Emily, John J. Prindle, and John M. Leventhal. 2016. “Prenatal Substance Exposure and Reporting of Child Maltreatment by Race and Ethnicity.” *Pediatrics* e20161273. doi: 10.1542/peds.2016-1273.

Rahders, Sonya Laddon. 2016. “Natural Incubators: Somatic Support as Reproductive Technology, and the Comparative Constitutional Implications on Cases of Maternal Brain Death in the U.S., Canada, and Ireland.” *Hastings Women’s Law Journal* 27(1):29–64.

Randall, Ronald. 1979. “Presidential Power versus Bureaucratic Intransigence: The Influence of the Nixon Administration on Welfare Policy.” *American Political Science Review* 73(3):795–810. doi: 10.2307/1955405.

Rawley, Callman. 1962. “Family Casework Diagnosis.” *Child Welfare*.

Raz, Mical. 2017. “Lessons From History: Parents Anonymous and Child Abuse Prevention Policy.” *Pediatrics* 140(6). doi: 10.1542/peds.2017-0340.

Raz, Mical. 2020. *Abusive Policies: How the American Child Welfare System Lost Its Way*. Chapel Hill: University of North Carolina Press.

Reich, Jennifer A. 2005. *Fixing Families: Parents, Power, and the Child Welfare System*. Taylor & Francis.

Riches, Julia K. 2001. "Fetal Attraction: The Politics of Fetal Protection in the Law." PhD Dissertation, Department of Government, Georgetown University.

Rindfleisch, Nolan, and Joel Rabb. 1984. "Dilemmas in Planning for the Protection of Children and Youths in Residential Facilities." *Child Welfare* 63:205–15.

Roberts, Dorothy. 1997. *Killing the Black Body: Race, Reproduction, and the Meaning of Liberty*. New York: Pantheon.

Roberts, Dorothy. 2002. *Shattered Bonds: The Color Of Child Welfare*. New York: Basic Civitas Books.

Roberts, Sarah C. M., Sue Thomas, Ryan Treffers, and Laurie Drabble. 2017. "Forty Years of State Alcohol and Pregnancy Policies in the USA: Best Practices for Public Health or Efforts to Restrict Women's Reproductive Rights?" *Alcohol and Alcoholism* 52(6):715–21. doi: 10.1093/alcalc/agx047.

Robertson, Stephen. 2005. *Crimes against Children: Sexual Violence and Legal Culture in New York City, 1880-1960*. Chapel Hill: The University of North Carolina Press.

Robins, Leonard. 1980. "The Plot That Succeeded: The New Federalism as Policy Realignment." *Presidential Studies Quarterly* 10(1):99–106.

Rodwell, Mary K., and Donald E. Chambers. 1989. "Promises, Promises: Child Abuse Prevention in the 1980s." *Review of Policy Research* 8(4):749–73. doi: 10.1111/j.1541-1338.1989.tb00994.x.

Rosenthal, Marguerite G. 2000. "Public or Private Children's Services? Privatization in Retrospect." *Social Service Review* 74(2):281–305. doi: 10.1086/514480.

Rostad, Whitney L., Tia McGill Rogers, and Mark J. Chaffin. 2017. "The Influence of Concrete Support on Child Welfare Program Engagement, Progress, and Recurrence." *Children and Youth Services Review* 72:26.

Roth, Rachel. 2003. *Making Women Pay: The Hidden Costs of Fetal Rights*. Ithaca, N.Y.: Cornell University Press.

Royer, Terry D., and Richard P. Barth. 1984. "Improving the Outcome of Pregnancy." *Social Work* 29(5):470–75.

Rymph, Catherine E. 2012. "From 'Economic Want' to 'Family Pathology': Foster Family Care, the New Deal, and the Emergence of a Public Child Welfare System." *Journal of Policy History* 24(1):7–25.

Sagatun-Edwards, Inger J., Coleen Saylor, and Bethany Shifflett. 1995. "Drug Exposed Infants in the Social Welfare System and Juvenile Court." *Child Abuse & Neglect* 19(1):83–91. doi: 10.1016/0145-2134(94)00103-2.

Saldaña, Johnny. 2015. *The Coding Manual for Qualitative Researchers*. New York, NY: Sage Publications.

SAMHSA. 2016. *A Collaborative Approach to the Treatment of Pregnant Women with Opioid Use Disorders*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment and Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau.

Sampson, Jerome N. 1962. "Is Child Welfare a Specialty?" *Child Welfare*.

Sandelowski, Margarete, Corrine I. Voils, and George Knafl. 2009. "On Quantitizing." *Journal of Mixed Methods Research* 3(3):208–22.

Schene, Patricia. 1987. "Remarks on the Key Points to Consider in Developing a System of CPS Risk Assessment." in *A Summary of the Highlights of the National Roundtable on CPS Risk Assessment and Family Systems Assessment: April 30 and May 1, 1987, San Francisco, California*, edited by T. Tatara. Washington, D.C.: American Public Welfare Association, Family Based Service Project.

Scherz, China. 2011. "Protecting Children, Preserving Families: Moral Conflict and Actuarial Science in a Problem of Contemporary Governance." *Political and Legal Anthropology Review* 34(1):33–50.

Schneider, Anne, and Helen Ingram. 1993. "Social Construction of Target Populations: Implications for Politics and Policy." *The American Political Science Review* 87(2):334–47. doi: 10.2307/2939044.

Schneider, Carol, Ray E. Helfer, and Carl Pollock. 1972. "The Predictive Questionnaire: A Preliminary Report." in *Helping the Battered Child and His Family*, edited by C. H. Kempe and R. E. Helfer. Philadelphia: Lippincott.

Schneider, Carol, James K. Hoffmeister, and Ray E. Helfer. 1976. "A Predictive Screening Questionnaire for Potential Problems in Mother-Child Interaction." in *Child Abuse and Neglect: The Family and the Community*. Cambridge MA: Ballinger Publishing Company.

Schottland, Charles I. 1974. "Book Review: Children and Decent People." *Child Welfare* 53(10).

Schroedel, Jean Reith. 2000. *Is the Fetus a Person? A Comparison of Policies across the Fifty States*. Ithaca, NY: Cornell University Press.

Schwartz, Molly. 2020. "Do We Need to Abolish Child Protective Services?" *Mother Jones*. Retrieved April 28, 2021 (https://www.motherjones.com/politics/2020/12/do-we-need-to-abolish-child-protective-services/).

Sealander, Judith. 2003. *The Failed Century of the Child: Governing America's Young in the Twentieth Century*. Cambridge UK; New York: Cambridge University Press.

Sedlak, Andrea J. 2001. *A History of the National Incidence Study of Child Abuse and Neglect*. Rockville, MD: Westat Inc./Children's Bureau - ACYF, DHHS.

Shyne, Ann W. 1953. *Statistics of Family Casework: 1952. Data from 60 Private Agencies of The Family Service Association of America.* New York: Family Service Association of America.

Shyne, Ann W., and Anita G. Schroeder. 1978. *National Study of Social Services to Children and Their Families*. Washington: Dept. of Health, Education, and Welfare, Office of Human Development Services, Administration on Children, Youth, and Families, Children's Bureau, National Center for Child Advocacy.

Simmons, Michaela Christy. 2020. "Becoming Wards of the State: Race, Crime, and Childhood in the Struggle for Foster Care Integration, 1920s to 1960s." *American Sociological Review* 85(2):199–222. doi: 10.1177/0003122420911062.

Simons, Betty, Elinor F. Downs, Madeline M. Hurster, and Morton Archer. 1966. "Child Abuse: Epidemiologic Study of Medically Reported Cases." *New York State Journal of Medicine* 66:2783–88.

Skocpol, Theda. 1985. "Bringing the State Back In: Strategies of Analysis in Current Research." in *Bringing the State Back In*, edited by P. Evans, D. Rueschemeyer, and T. Skocpol. Cambridge: Cambridge University Press.

Skocpol, Theda. 1992. *Protecting Soldiers and Mothers: The Political Origins of Social Policy in United States*. Cambridge, Mass: Belknap Press.

Skocpol, Theda, and Kenneth Finegold. 1982. "State Capacity and Economic Intervention in the Early New Deal." *Political Science Quarterly* 97(2):255–78. doi: 10.2307/2149478.

Skolnick, Andrew. 1990a. "Cocaine Use in Pregnancy: Physicians Urged to Look for Problem Where They Least Expect It." *JAMA* 264(3):306–9. doi: 10.1001/jama.1990.03450030018003.

Skolnick, Andrew. 1990b. "Drug Screening in Prenatal Care Demands Objective Medical Criteria, Support Services." *JAMA* 264(3):309–10. doi: 10.1001/jama.1990.03450030023004.

Skowronek, Stephen. 1982. *Building a New American State: The Expansion of National Administrative Capacities, 1877-1920*. Cambridge Cambridgeshire ; New York: Cambridge University Press.

Small, Mario Luis. 2011. "How to Conduct a Mixed Methods Study: Recent Trends in a Rapidly Growing Literature." *Annual Review of Sociology* 37:57–86.

Smith, Rebecca. 1968. ""For Every Child." A Commentary on Developments in Child Welfare 1962-1967." *Child Welfare*.

Soifer, Hillel. 2008. "State Infrastructural Power: Approaches to Conceptualization and Measurement." *Studies in Comparative International Development* 43(3–4):231. doi: 10.1007/s12116-008-9028-6.

Solinger, Rickie. 1998. *Abortion Wars: A Half Century of Struggle, 1950-2000*. Berkeley: University of California Press.

Soss, Joe, Richard C. Fording, and Sanford Schram. 2011. *Disciplining the Poor: Neoliberal Paternalism and the Persistent Power of Race*. Chicago; London: University of Chicago Press.

SSB. 1950. *Services for Children: Three Programs of the Children's Bureau*. Children's Bureau, Division of Research, Program Research Branch.

Stack, Carol B. 1983. *All Our Kin: Strategies for Survival in a Black Community*.

Starr, R. H. 1978. "The Controlled Study of the Ecology of Child Abuse and Drug Abuse." *Child Abuse & Neglect* 2(1):19–28. doi: 10.1016/0145-2134(78)90003-0.

Starr, Raymond., ed. 1982. *Child Abuse Prediction: Policy Implications*. Cambridge, Mass.: Ballinger.

Stearns, Peter. 2004. *Anxious Parents: A History of Modern Childrearing in America*. New York: NYU Press.

Steensland, Brian. 2006. "Cultural Categories and the American Welfare State: The Case of Guaranteed Income Policy." *American Journal of Sociology* 111(5):1273–1326. doi: 10.1086/499508.

Steensland, Brian. 2008. *The Failed Welfare Revolution: America's Struggle Over Guaranteed Income Policy*. Princeton University Press.

Stehno, Sandra M. 1990. "The Elusive Continuum of Child Welfare Services: Implications for Minority Children and Youths." *Child Welfare* 69(6).

Steiner, Gilbert Yale. 1971. *The State of Welfare*. Brookings Institution.

Strouse, Carol J. 1990. "Revisiting Florida's Risk Assessment Efforts: A State Update." in *CPS Risk Assessment Conference - From Research to Practice: Designing the Future of Child Protective Services*, edited by Vermont Division of Social Services, American Public Welfare Association, and American Association for Protecting Children. Burlington, Vt.: Vermont Division of Social Services, American Public Welfare Association, American Association for Protecting Children.

Sweet, Paige L. 2019. "The Paradox of Legibility: Domestic Violence and Institutional Survivorhood." *Social Problems* 66(3):411–27. doi: 10.1093/socpro/spy012.

Tani, Karen M. 2016. *States of Dependency: Welfare, Rights, and American Governance, 1935-1972*. New York: Cambridge University Press.

Tatara, Toshio, ed. 1987a. *A Summary of the Highlights of the National Roundtable on CPS Risk Assessment and Family Systems Assessment: April 30 and May 1, 1987, San Francisco, California*. Washington, D.C.: American Public Welfare Association, Family Based Service Project.

Tatara, Toshio. 1987b. "An Overview of Current Practices in CPS Risk Assessment and Family Systems Assessment in Public Child Welfare." in *A Summary of the Highlights of the National Roundtable on CPS Risk Assessment and Family Systems Assessment: April 30 and May 1, 1987, San Francisco, California*, edited by T. Tatara. Washington, D.C.: American Public Welfare Association, Family Based Service Project.

Thomas, Sue, Ryan Treffers, Nancy F. Berglas, Laurie Drabble, and Sarah C. M. Roberts. 2018. "Drug Use During Pregnancy Policies in the United States From 1970 to 2016:" *Contemporary Drug Problems*. doi: 10.1177/0091450918790790.

Thompson, Elizabeth L. 1989. "The Criminalization of Maternal Conduct During Pregnancy: A Decisionmaking Model for Lawyers." *Indiana Law Journal* 64(2).

Thornton, Patricia H., William Ocasio, and Michael Lounsbury. 2012. *The Institutional Logics Perspective: A New Approach to Culture, Structure, and Process*. Oxford; New York: Oxford University Press.

Tomkins, Alan J., Michael Steinman, Mary K. Kenning, and Somaia Mohamed. 1992. "Children Who Witness Woman Battering." *Law & Policy* 14(Issues 2 & 3):169–84.

Trattner, Walter I. 1999. *From Poor Law to Welfare State: A History of Social Welfare in America*. The Free Press.

USA Human Resources Division. 1990. *Drug-Exposed Infants - a Generation at Risk: Report to the Chairman, Committee on Finance, U.S. Senate*. Washington, D.C. :

USDHHS. 1990. *Research on Children, Youth, and Families: 1986-1990*. US Department of Health and Human Services.

Vega, William A., Bohdan Kolody, Jimmy Hwang, and Amanda Noble. 1993. "Prevalence and Magnitude of Perinatal Substance Exposures in California." *New England Journal of Medicine* 329(12):850–54. doi: 10.1056/NEJM199309163291207.

Wald, Michael S., 1941-, and Maria Woolverton. 1990. "Risk Assessment: The Emperor's New Clothes?" *Child Welfare* 69:483–511.

Wang, Ching-Tung, and Deborah Daro. 1997. *Current Trends in Child Abuse Reporting and Fatalities: The Results of the 1997 Annual Fifty State Survey*. Chicago, IL: The Center on Child Abuse Prevention Research, a program of the National Committee to Prevent Child Abuse.

Weber, Max. 1978. *Economy and Society: An Outline of Interpretive Sociology*. University of California Press.

Weinberger, Paul E., and Peggy J. Smith. 1966. "The Disposition of Child Neglect Cases Referred by Caseworkers to a Juvenile Court." *Child Welfare*.

Weiss, Linda. 2006. "Infrastructural Power, Economic Transformation, and Globalization." P. 167 in *An Anatomy of Power: The Social Theory of Michael Mann*, edited by J. A. Hall and R. Schroeder.

Whipple, E. E., and C. Webster-Stratton. 1991. "The Role of Parental Stress in Physically Abusive Families." *Child Abuse & Neglect* 15(3):279–91. doi: 10.1016/0145-2134(91)90072-l.

White, Adam. 2013. *The Everyday Life of the State: A State-in-Society Approach*. Seattle: University of Washington Press.

Whiteman, Rodney S., Brendan D. Maxcy, Erica Fernández, and Samantha M. Paredes Scribner. 2017. "Policy Enactments and Critical Policy Analysis: How Institutional Talk Constructs Administrative Logics, Marginalization, and Agency." Pp. 175–91 in *Critical Approaches to Education Policy Analysis: Moving Beyond Tradition*, *Education, Equity, Economy*, edited by M. D. Young and S. Diem. Cham: Springer International Publishing.

Wiese, David, and Deborah Daro. 1995. *Current Trends in Child Abuse Reporting and Fatalities: The Results of the 1994 Annual Fifty State Survey*. Chicago: National Center on Child Abuse Prevention Research, a program of the National Committee to Prevent Child Abuse.

Wilson, Dee. 1989. “An Interpretive Essay - Child Protective Services: A Working Agenda.” in *Research Issues in Risk Assessment for Child Protection*, edited by Kathern. Bond and Patricia. Schene. Denver, Colorado: American Association for Protecting Children.

Winston, Ella. 1960. “What Lies Ahead in Public Services for Children.” *Child Welfare*.

Winston, Ellen. 1966. “The Shape of Things to Come in Child Welfare: The Broad Outline.” *Child Welfare*.

Witte, Ernst F. 1962. “Dealing with Manpower Problems in Social Work.” *Child Welfare*.

Wolock, Isabel, and Bernard Horowitz. 1979. “Child Maltreatment and Material Deprivation among AFDC-Recipient Families.” *Social Service Review* 53(2):175–94.

Yang, Mi-Youn. 2015. “The Effect of Material Hardship on Child Protective Service Involvement.” *Child Abuse & Neglect* 41:113–25. doi: 10.1016/j.chiabu.2014.05.009.

Zelizer, Viviana A. Rotman. 1985. *Pricing the Priceless Child: The Changing Social Value of Children*. New York: Basic Books.

Zunder, Phillip M. 1990. “Recent Empirical Findings of the Vermont Family Risk Assessment Instrument.” in *CPS Risk Assessment Conference - From Research to Practice: Designing the Future of Child Protective Services*, edited by Vermont Division of Social Services, American Public Welfare Association, and American Association for Protecting Children. Burlington, Vt.: Vermont Division of Social Services, American Public Welfare Association, American Association for Protecting Children.

METHODOLOGICAL APPENDIX

Introduction

The methodological appendix is divided into two parts: the first discusses the data and methods used in this dissertation; the second provides an overview of selected data and analytic coding used, as well as a list of the undergraduate research assistants that supported this project. The multi-method approach that the dissertation utilized to obtain the research findings are the result of two related research questions: How did child welfare agencies become institutionalized as the primary regulatory authority over American families? How did this institutionalization aid in the expansion of their authority over substance-exposed infants? Answering these questions required a circuitous path through four different kinds of data collection and analysis. This data was not collected in order of the narrative. I began my research by first trying to understand how child welfare became the primary authority over substance-exposed infants, and I collected and analyzed legal and policy data on the issue (data and method 1 below). I then began collecting data on the institutionalization of child welfare (data and methods 2, 3, and 4 below). It was at this point, after collecting and analyzing dissertation data on the development of child welfare authority in the 1950s-1980s (Chapter 3) and the increasing focus on substance-exposed infants (Chapter 6 and part of Chapter 5), that a crucial gap in the story emerged: while the data on substance-exposed infants showed a strong focus on conceptions of risk, the existing literature did not explain how child welfare had become so focused on risk or how that became linked to the expansion of child welfare jurisdiction over an increasing number of parental behavioral issues, including maternal behaviors in the perinatal period. To address this gap, I used a version of method 3 to collect professional discourse data that formed the basis of Chapter 4 and most of Chapter 5. Through this iterative and perhaps inefficiently laborious process, a story of professional institutionalization and legitimation emerged, one that provides a new account of how child welfare became the regulatory authority over American children, from womb to adulthood.

Part 1: Data and Methods

The data and methods used in this dissertation can be loosely categorized into four approaches:

A. Legal-historical research

This method focused on understanding the development of complex policies that often vary by state and that were revised over time. Such policies include substantive federal and state laws that regulate how interventions in cases of substance-exposed infants unfold. To conduct this research, I began with online resources, such as Westlaw, a legal database that provides information on federal and state laws and some historical data on legal development. Other online databases include Congressional Proquest, which contains detailed documentation on federal laws related to child welfare, including Social Security Act revisions (documented in Chapter 3), and the passage and revisions to CAPTA, AACWA, and ASFA. For state-level research, I found limited online state archives, which provide historical documents on older state laws. To dig deeper into the passage of state laws from the 1980s and 1990s, however, online sources did not suffice, and I visited local archives to collect materials. These included the California State Archives in Sacramento, California, and the microfilm and archival text sources

on California legal histories in the University of California, Berkeley Law School. These materials provided me with data that explained why some state laws passed and others failed.[144]

As part of this legal research, I sought to document changes in child maltreatment mandated reporting laws from the 1960s to the early 2000s. The goal of this project was to examine how surveillance of families shifted, who was the primary authority charged with interventions in families by legislators, and how that authority shifted over time. The challenge with this data is that mandated reporting laws vary by state and are revised in ensuing years, and so to investigate this issue required tracking fifty sets of laws over multiple decades. My approach to this was to choose one point roughly in the middle of each decade from 1960-2000; I then used a combination of fifty-state surveys published during that period and Westlaw to document these laws from 1950-1997. Specifically, the goal was to track: 1) mandated reporters: how the number of reporters changed over time, what professions were given this responsibility and how that shifted over the decades, and 2) reporting authorities: whom did legislators consider the appropriate authorities to receive and investigate such reports. I used this data to support my argument in Chapter 3 (Figure 6 and Table 1).

B. Archival research

Archival non-legal research was used primarily for Chapter 3, to better understand the significant transformations in child welfare from 1935-1980. To track these professional developments from the Social Security Act of 1935 until today, I used traditional and online archives, and a combination of standard archival analysis and innovative techniques. First, I made several visits to the National Archives and Records Administration (NARA) in College Park, Maryland, where I found archival sources on the development of child welfare issues from 1950-1980, as well as data on the reorganization of the Children's Bureau in the 1960s. I also found materials that helped me track down publications of the Children's Bureau, specifically the "U.S. Children's Bureau Statistical Series," or CBSS (1945-1968). This series included historical surveys on child welfare services during this period, and, as published materials, were available online on Hathitrust.org, a source for a wide range of published historical documents. In addition, I was able to track down other important reports and surveys on child welfare from organizations that included the Children's Bureau, the Child Welfare League of America, the American Humane Association, either on Hathitrust or as hard copies in several federal depository libraries, including Princeton University, University of Pennsylvania, and University of California, Berkeley. Federal depository libraries are research libraries (usually affiliated with a university) that receive copies of materials published by government agencies. This data was used primarily to explain the transformation of child welfare in Chapter 3, but it also supported arguments in Chapters 4 and 5 on the development of risk assessment tools and contextual policy trends.

In addition to reviewing documentary materials to track development of policies, discussions of organizational changes, and shifts in administrative logics in American federal agencies, I also sought to use the historical surveys and other sources to reconstruct the infrastructural expansion of child welfare, documented in Chapter 3. I accomplished this by working with a team of undergraduate researchers, who helped me input relevant data from three sets of surveys (CBSS, AHA, and NCPCA – see more details in Methodological Appendix – Part

[144] Details on the justification for selecting the specific states for case studies can be found in Chapter 6.

2) into spreadsheets, so that the data could be analyzed for changes over time. The CBSS data allowed me to analyze changes in child welfare funding, staffing, and services from 1945-1967, as discussed in Chapter 3, where some of it is illustrated in charts (Figures 1 and 2). To track changes after the decline of the Children's Bureau, I also reviewed additional statistical survey materials produced or co-produced from 1970-2000 by the Department of Health, Education, and Welfare, later reorganized and renamed the Department of Health and Human services; these included stand-alone reports as well as series data such as the Voluntary Cooperation Information System (VCIS) on foster care data. I supplemented survey data with directory data that enabled visualizations of the expanding infrastructural capacity of child welfare. Working with a team of undergraduate assistants, we input Child Welfare League of America directory data on affiliated child welfare agencies for five decades: 1950, 1961, 1971, 1981, 1991, and 2000. Because this included address data, we were able to transform data from 1951-1981 into maps of child welfare agencies, using ARCGIS, a geospatial mapping program. (Some of the later data, especially 1991, turned out to have some data consistency issues, which I am still evaluating, and so we only used maps from earlier decades.) These maps, shown in Chapter 3, reinforce the argument for child welfare's infrastructural expansion, which undergirds the main claims of this dissertation.

Finally, to track changes in discussions of maltreatment and reporting data, I worked with a team of undergraduates to input data from surveys on child maltreatment by the American Humane Association (AHA, 1976-1987) and from the National Committee to Prevent Child Abuse (NCPCA, 1986-2000). Analyzing this data for changes over time, I could support arguments on how reports rose, the largely professional sources of reporting, and the specific kinds of reports made during this period. For some of the later years, reports and data are already available online, and thus did not require input, from the National Incidence Studies (NIS) and the National Child Abuse and Neglect Database (NCANDS). These surveys enabled me to track how definitions of abuse and fetal harm shifted over time, as well as extensive data on reporting sources.

C. Journal analysis

The data described above provided information on larger national and state-level shifts and polices related to child welfare and substance-exposed infants. To explain how these shifts were interpreted in the practices and discourses of professionals engaging with families, I conducted in-depth content analysis of professional journals. Seeking to conduct analysis that was sensitive to both meso-level professional shifts over time, and to the specific discourses and practical concerns of child welfare at specific times, I co-developed a 6-step analytical method, called Complex Text Coding (Lichtenstein and Rucks-Ahidiana 2020), which accounts for both quantitative trends and qualitative trends across a large number of texts. CTC is particularly useful for analyzing historical documents over time, such as journals published over several years or decades. The main components of this method are described as follows:

> The CTC method provides six detailed steps through which researchers analyze a large corpus of complex texts, such as newspaper, journal, or interview data, by tracking and analyzing narratives, discourses, or events, including their prevalence, frequency, and content. Building on traditional qualitative analytical approaches, CTC begins by compiling relevant data and defining the research question and corresponding unit of analysis. With that information, the researcher constructs a spreadsheet with deductive codes, revises and expands those codes to include new inductive codes, and applies the

> codes to the full corpus of data. The spreadsheet format enables analysis for quantitative trends in the qualitative data, building on approaches that quantitize qualitative data (Becker 1970; Saldaña 2015; Sandelowski, Voils, and Knafl 2009; Small 2011). Finally, the researcher analyzes the quantitized data for themes and trends that motivate targeted qualitative analysis of specific subsets of the data. (Lichtenstein and Rucks-Ahidiana 2020)

I applied the CTC method in two large textual data collection projects, and I applied a modified version of CTC to a smaller journal analysis project. The three projects are described here:

1. *Child Welfare Journal*

I sought to track changes in discourses in the child welfare field over the 1950-1990 period, seeking to shed light on how norms and practices evolved during this crucial era of child welfare development. I selected the *Child Welfare* journal to track these discourses because it is the only journal that has been consistently published throughout most of the twentieth century (1921-present, ten months a year until 1982, at which point it became bi-monthly), and it is a flagship child welfare journal that included articles by researchers, practitioners, and legal advocates involved in child welfare in 1950-1990 period. I worked with a team of undergraduates to collect, scan, and code journals from every second year during this period, collecting data both on the main topics of each article for 1950-1990, as well as tracking nine primary coding themes and seventeen sub-codes throughout the 1960-1990 period.[145] (See Methodological Appendix - Part 2 for a list of thematic codes.) In total, we analyzed 1,923 *Child Welfare* articles for this project. In addition to tracking quantitative trends in discourses (as discussed in Chapter 3), the qualitative thematic coding allowed for in-depth analysis of shifts in child welfare norms. To further analyze this topic, I selected from the coded articles for additional research using MAXQDA, a qualitative software program, focusing specifically on articles coded for neglect, poverty, and risk from 1960-1990. The qualitative coding method followed classical qualitative analysis approaches (Patton 2002; Saldaña 2015). The results of this research can be seen throughout Chapters 3-5, where *Child Welfare* journal articles are frequently cited to ground some of the macro-level analysis of child welfare policy changes. This is especially evident in the analysis of discussions of neglect in Chapter 4.

2. *Substance-exposed infants: multi-disciplinary analysis*

For Chapters 4 and 5, I sought to track changes in professional discourses related to SEI across multiple disciplines from 1978-2000, a crucial period for the development of professional and policy practices related to this issue. To find these articles, I used multiple journal databases (JSTOR, Elsevier, NEJM, JAMA, and Wiley, among others) to select articles from journals in four professions: public health, medical, social work/child welfare, and bioethics/law. I developed a set of twelve search terms (modified slightly for the technical requirements of specific database search programs) to find articles related to this topic (see Methodological Appendix - Part 2 for a list of search terms). With the assistance of undergraduate researchers, we reviewed approximately 4,500 journal article results and distilled it to 123 most relevant articles for in-depth CTC analysis (see Chapter 5, Table 4). In addition to coding for descriptive data (date of publication, author name, degree of author, location of research), we also coded

[145] I later added a smaller selection of thematic coding for 1956-1958.

these articles for a set of nine primary codes and eleven sub-codes (see Methodological Appendix - Part 2 for a list of thematic codes). This coding allowed me to track discussions of risk, race, poverty, maltreatment, and authority across multiple disciplines. Content analysis revealed specific discussions of risk and modes of assessment of substance-exposed infants that varied by discipline and over time and were linked to particular ideas of authority. Note that for the dissertation, I focused my analysis on medical and social work/child welfare journals; the results of this analysis are in described in Chapter 5, where I use the data to argue for how child welfare became the primary profession authorized to intervene in SEI cases.

3. *Risk Analysis*

In a third journal analysis project, I applied a modified version of the CTC method. For this narrower research topic, I sought to understand how child welfare researchers and practitioners understood concepts of risk, both in their general practices and in the development of risk assessment instruments from 1978-2000. What kind of risk factors did they assess, and did they account for or conflate poverty, race, gender, and other issues with maltreatment? How did researchers assess (or not) the validity and reliability issues of these instruments, especially false positives and negatives, which could lead to long-term implications for families? Finally, in my analysis, I tracked the actors involved in the risk assessment process, seeking to uncover if these actors included just social workers and child welfare agency administrators and researchers or professionals from other fields, such as medical and legal professionals. My goal was to track the construction of risk, whether risk became conflated with structural inequality, and how the actors involved influenced how risk assessment tools affected families and eventually expanded child welfare surveillance to the womb. To answer these questions, I examined the following data. First, I selected two flagship child welfare journals: *Child Welfare* and *Child Abuse and Neglect*. With the help of undergraduate researchers, I conducted digital searches for articles related to "risk assessment" from 1978-2000, a crucial period in risk assessment development. I systematically analyzed these articles by asking the same questions noted above with each article.

I then used these articles as springboard to find reports, highly cited pre-1978 journal articles, and conference materials specifically on risk assessment. I found multiple examples of preliminary and more advanced tools, as described in state agency reports that explained the tools' development, evaluation, and context. Tools were also discussed in conferences focused specifically on risk assessment in child welfare in 1987, 1989, and 1999, with detailed reports that I analyzed as part of this research. To assess the impact of these instruments and conceptions of risk on broader child welfare practice, I also analyzed National Conference on Abuse and Neglect (NCCAN) reports from 1976-1989, by conducting searches for risk, assessment, and screening, as part of a broader review. Lastly, I contextualized this study with a longitudinal analysis of AHA and NCANDS data on maltreatment reports and reporting sources, as well as quantification and analysis of mandated reporting laws.

D. Interviews

While this dissertation focused primarily on documentary sources, I sought to triangulate my analysis with purposive interviews. Purposive interviews focus on specific individuals with the knowledge to fill in narrative gaps that the documents cannot explain. In total, between 2016-2019, I conducted interviews with seventeen individuals (along with three additional follow-up interviews), which supplemented my understanding of the California and Wisconsin cases, as

well as the development of national surveys and the operation of national child welfare organizations.

Part 2: Data Sources and Research

This second section of the methodological appendix provides additional details on some of the sources and coding methods used. I also include a list of the undergraduate assistants who made much of this research possible at the end of the appendix.

Historical survey sources

The following major surveys form the basis of the survey data for this paper. Note that the first three were only available as hard copy or digitized PDFs, and thus required a data-input process of selected survey data before they could be analyzed:

1) The "U.S. Children's Bureau Statistical Series" produced by the Children's Bureau from 1945-1968, provides organizational data that demonstrate shifts in child welfare organizational capacity.

2) The American Humane Association (AHA) studies conducted in cooperation with the federal government (DHEW and later DHHS) during the 1976-1987 period, provide data on child abuse reports and characteristics of families supervised by child welfare.

3) The "Annual 50-State Survey" reports from 1986-2000 by the National Committee for the Prevention of Child Abuse, a private non-profit. These surveys document changing issues of interest in child welfare and increased rates of particular kinds of abuse and neglect, as reported by the federal liaison to child welfare in all cooperating states. This data also reveals how child welfare began its involvement with substance-exposed infants.

4) National Incidence Studies (NIS) published in 1981, 1988, 1996, and 2010 by the federal government, specifically the Department of Health and Human Services (DHHS).

5) The National Child Abuse and Neglect Data System (NCANDS) reports, a federal Department of Health and Human Services effort to track child abuse reports and investigations in every state by the 1992-present, which also reveals changes in child welfare researchers' interest in substance-exposed infants. Original datasets are available upon request from NCANDS, and a selection of study results are published in annual "Child Maltreatment" reports (1995-2019) by the Children's Bureau.

Interpretive coding themes for* Child Welfare *journal analysis

Abuse (three sub-codes)
Neglect (three sub-codes)
Poverty
Parental Rights
Intervention (five sub-codes)
Pregnancy
Race
Policy
Administration (six sub-codes)

***Proportion of annual primary topic mentions (1960-1990) in* Child Welfare**

Date	Abuse	Neglect	Poverty	Parental.Rights	Intervention	Pregnancy	Race	Policy	Administration
1960	0.029	0.120	0.101	0.048	0.091	0.101	0.091	0.082	0.337
1962	0.054	0.121	0.136	0.061	0.125	0.093	0.071	0.093	0.246
1964	0.048	0.131	0.157	0.035	0.092	0.057	0.109	0.092	0.279
1966	0.050	0.100	0.145	0.059	0.118	0.091	0.100	0.091	0.245
1968	0.046	0.085	0.162	0.038	0.054	0.154	0.108	0.108	0.246
1970	0.073	0.106	0.173	0.056	0.112	0.084	0.123	0.056	0.218
1972	0.051	0.096	0.162	0.096	0.066	0.074	0.081	0.088	0.287
1973	0.095	0.103	0.147	0.086	0.069	0.017	0.086	0.052	0.345
1974	0.100	0.118	0.135	0.088	0.094	0.041	0.112	0.076	0.235
1975	0.127	0.101	0.101	0.051	0.095	0.082	0.095	0.051	0.297
1976	0.124	0.113	0.102	0.065	0.134	0.032	0.086	0.048	0.296
1978	0.118	0.126	0.079	0.055	0.157	0.024	0.071	0.110	0.260
1979	0.170	0.151	0.066	0.019	0.226	0.057	0.038	0.057	0.217
1980	0.160	0.153	0.069	0.076	0.160	0.031	0.038	0.053	0.260
1982	0.149	0.096	0.088	0.035	0.096	0.061	0.096	0.114	0.263
1984	0.188	0.125	0.094	0.052	0.125	0.042	0.104	0.104	0.167
1986	0.198	0.151	0.035	0.081	0.140	0.023	0.047	0.140	0.186
1988	0.204	0.150	0.062	0.080	0.106	0.018	0.053	0.133	0.195
1990	0.202	0.137	0.073	0.056	0.129	0.024	0.073	0.105	0.202

Interpretive coding themes for SEI journal coding

Article Type (Prescriptive/Descriptive)
Intervention
Exposure
Health
Maltreatment (five sub-codes)
Risk (two sub-codes)
Poverty
Race
Authority (four sub-codes)

Search terms used in digital journal searches related to SEI

1. (“pregnancy substance” ~25)
2. (“pregnant substance”~25)
3. ("pregnancy drug"~25)
4. ("pregnant drug"~25)
5. ("pregnancy drugs"~25)
6. ("pregnant drugs"~25)
7. ("pregnancy alcohol"~25)
8. ("pregnant alcohol"~25)

9. (“substance exposed infants”)
10. ((“maternal substance abuse”) OR (“maternal substance use”))
11. (“neonatal abstinence syndrome”)
12. (“fetal alcohol syndrome”)

Undergraduate Research Assistants
Kylie Choi
Susannah Conine-Nakano
Alicia Cuevas
Casey Costello
Mariah Fiel
Nathan Fillingim-Selk
Emma Finney
Natalie Gonzalez
Trevor Greenan
Sofia Guo
Camilla Hamideh
Gopika Jalan
Tara Madhav
Daniel Milutin
Kavya Nambiar
Tuong-Vi Nguyen
Hannah Rasekhi
Danielle Santos
Shasun Sulur
Kamryn Sung
Tiger (Ka Kit) Tam
Amanda Tjan
Claudia Trost
Raymond Wang
Hannah Wasserman