

The Helping to End Addiction Long-term[®] Initiative

**Engaging Child Welfare Systems in Research
on Young Children Hybrid Workshop**

Zoom and Bethesda, MD

May 25-26, 2023



Meeting Summary

HEAL Initiative Engaging Child Welfare Systems in Research on Young Children Hybrid Workshop



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Meeting Report

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Opening Session

(Michelle Freund, HBCD; Rebecca G. Baker, HEAL Director; Nora D. Volkow, NIDA Director; Brenda Jones Harden, HBCD)

Introductions *(Michelle Freund, National Institute on Drug Abuse [NIDA])*

Dr. Freund introduced herself as the Director of the HEALthy Brain and Child Development Study (HBCD), a study that is sponsored by the Helping to End Addiction Long-term (HEAL) initiative as well as 10 other institutes and centers across the National Institutes of Health (NIH). She provided an overview of the purpose of the workshop, noting that the meeting was being recorded and would be posted on the HEAL website and NIDA website. She thanked the HEAL initiative for sponsoring the workshop, as well as logistics contractors and the workshop planning committee. The committee is a subgroup of the HBCD Transitions in Care Working Group, led by Dr. Jones Harden (University of Maryland) and Judge Peggy Walker, who could not join the meeting because of travel for work. Dr. Freund also thanked Chloe Jordan, Ph.D., and Kathy Cole, Ph.D., from NIDA, who worked directly with Dr. Freund, and introduced Dr. Baker, Director of the HEAL initiative.

Dr. Baker welcomed meeting participants and noted that she works in the NIH Office of the Director where she oversees the NIH HEAL Initiative; the initiative is very pleased to help sponsor the workshop. Dr. Baker thanked organizers, the research community, and other partners for addressing this important research area that has not gotten the attention it deserves. The NIH HEAL initiative is committed to working with the research community to provide scientific solutions to the opioid crisis and the many ways it is affecting people and families across the United States. Many problems are nested within this crisis, including substance use, mental health, untreated pain, and structural inequities. These are all connected at some level, and HEAL aims to focus not only on the diseases,

conditions, and treatments but also on the practical issues that affect individuals and families. Infancy and childhood are critical periods for both children and mothers, and the needs of these families are a key area of research focus for the HEAL initiative. Dr. Baker thanked Dr. Freund and other team members for their consideration of these issues during the past several years leading up to the workshop.

Finding and implementing the best approaches to address the medical and social needs of children as they grow are critical for the future health of the country. NIH is beginning to see signs of return on its research investment through the HEAL initiative, including new findings from the Advancing Clinical Trials in Neonatal Opioid Withdrawal (ACT NOW) research program that showed that the Eat, Sleep, -Console (ESC) care approach for infants born exposed to opioids during a mother's pregnancy reduced the length of hospital stays by nearly 7 days for babies experiencing extreme discomfort and withdrawal symptoms. The ESC approach also reduced infants' need for opioid medications to recover from withdrawal symptoms by 63 percent. This is just one example of the body of research HEAL supports to address the needs of families, and especially infants and children, affected by the opioid crisis.

One of the guiding principles for HEAL research is to address the systemic inequities that prevent people from receiving high-quality care. Everyone in this country deserves effective treatment for substance use disorder (SUD) or other health conditions, and in order to achieve this goal, research needs to align with the need to confront and overcome inequities such as bias, discrimination, housing insecurity, transportation needs, and food insecurity. The HEAL prevention research portfolio has incorporated research on a range of community

systems involving different populations with substantial risk, including individuals in the carceral-legal system. Last year, this research demonstrated that by providing medication-based treatment in jails in Massachusetts, recidivism and rearrest were reduced by 30 percent when compared with jails and communities that did not offer treatment. Other HEAL research offers ideas for enhancing safe housing for homeless youth, helping individuals in juvenile detention centers to deal with past trauma, guiding children in afterschool programs to avoid risky behaviors, and promoting other practical strategies to help reduce the risk of opioid misuse, mental health, and other health challenges. HEAL is also funding prevention research to address the needs of families referred to the child welfare system (CWS) for severe substance use related to methamphetamine or opioids and for child neglect. In addition to treatment for SUD, the program also delivers parental skills training, mental health treatment, and help with ancillary services such as housing and employment. The work done in this workshop and after this workshop will really begin to expand on this research and address the needs of individuals and families who are often left behind but are bearing the burden of this increasingly challenging public health crisis.

Dr. Volkow (Director, NIDA) was unable to attend the workshop, but provided a prerecorded message. In it, she welcomed participants to the first workshop of its kind on engaging the CWS in research on young children. The workshop is an opportunity to gather individuals from the research community and families who have been affected by and participated in the CWS to hear from one another and create a path to future collaborations between classic academic centers sponsored through NIH that respond to needs for data and interventions that can improve the outcomes of children who end up in the CWS. As researchers in SUD, meeting participants know and are sensitive to the fact that one of the consequences of parental substance use is that sometimes their children end up in the CWS, foster care, or other institutions. One surprising aspect is how little research has been done on this intersection, examining the outcomes when children whose parents are using drugs are sent into the CWS and when these children are placed in foster homes. The quality of the foster home will have a large impact on these outcomes, but it is also important to understand whether interventions targeted to strengthening families may be preferable and result in better outcomes than

raising children in the CWS and foster care. Research is needed to obtain the knowledge that can inform optimal intervention and determine which practices yield the best outcomes. Dr. Volkow noted that she looks forward to any recommendations regarding this research that may be identified during the workshop.

Dr. Jones Harden thanked Dr. Freund for providing intellectual leadership for HBCD and managing 25 HBCD sites across the country and for her foresight in putting together the workshop. Dr. Jones Harden also thanked the workshop committee, led by Julie Poehmann, Ph.D. (University of Wisconsin-Madison), and all colleagues in child welfare who made time to participate. There has been a disconnect between NIH and all of the work that is happening in child welfare across the country, and the workshop is an opportunity to hear about all of this work and demonstrate to NIH that this is an area deserving of more funding.

HBCD's key question is "what is the impact of early adversity on children's brain and behavioral development?" It is not possible to ask that question without considering children in the CWS, in that the CWS is really a proxy for adversity, because when children end up in the CWS it is because all other systems have failed them. These children have experienced a range of contextual adversity factors. The CWS itself creates some adversity for children, and in HBCD, the research is looking at outcomes related not only to what children bring to the world in terms of their physiology but also to their environmental experiences. Child welfare is one of those experiences, and the HBCD Transitions in Care Working Group will be emphasizing the importance of asking questions about children's experiences in the CWS because of their impact on outcomes. National data on children in the CWS demonstrate that infants are the children who have the highest rates of maltreatment, fatalities, and foster care placement. HBCD is trying to look at very young children, beginning in the prenatal period, and given the epidemiological data on these children, it is critical that HBCD consider their experiences from the perspective of the CWS. The workshop has brought together some of the top experts in the CWS, including Dr. Jones Harden's colleague, Bryan Samuels, M.P.P. (University of Chicago). Mr. Samuels has a personal investment in seeing that children in the CWS get the attention they deserve. He previously ran a CWS in Illinois, is a former head of the Children's Bureau, and

is currently the director of Chapin Hall, one of the few research-to-policy think tanks in the country. Chapin Hall began as an orphan asylum, one of the first institutions in the CWS, and years later converted to a policy think tank with the goal of using research to inform policy, particularly with regard to this population of children.

Families at Risk for Child Welfare Involvement (Bryan Samuels, Chapin Hall)

Mr. Samuels thanked Dr. Jones Harden for the introduction and described himself as a “recovering policymaker,” noting that much of his presentation would be presented from this perspective. His goals for the presentation included (1) to discuss the front end of the CWS and the ways in which policies are evolving; (2) to discuss the population of children and families who are involved in the CWS; and (3) to point out where the data are that create the opportunity to have some of the current debates over where the CWS should be going.

The CWS exists against an evolving policy framework, and today’s data may be very different from that of 10 years ago, and that is largely a function of policy changes. The Adoption Assistance and Child Welfare Act of 1980 focused on subsidizing adoption, specifically accelerating the pace at which children leave the CWS to be adopted by eliminating the cost associated with the services those children might need after adoption. The infrastructure around which child welfare has been built over the past 20 years was established in 1997 with the Adoption and Safe Families Act (ASFA), which articulated the meaning of safety, permanency, and well-being and set time limits on how long a child could stay in the CWS before determination of best interest is made. ASFA also articulated that children have rights, too, and that the CWS should be able to balance the rights of the parents with the rights of children. Between 2012 and 2014, Title IV-E Prevention Program waivers were created by Congress as an opportunity for states to manage their own CWS while also continuing to receive funding from the federal government. This was the first time that the

federal government indicated an interest in evidence-based practices; in order to receive a Title IV-E waiver, states had to propose using evidence and evidence-based programs in a particular way to move the CWS system forward. In 2018, the Family First Prevention Services Act (FFPSA) was introduced; this was the first time that the federal government made significant contributions to preventing children and families from entering the CWS. The FFPSA, at its most basic level, targeted services to families with mental health problems, substance misuse problems, and parenting problems. This is the first time that policy identified a unique population of parents around which the CWS was trying to organize a set of policies and practices to meaningfully meet the needs of these families and, in doing so, prevent them from entering the CWS.

Data for 2021 from the National Child Abuse and Neglect Data System (NCANDS) reflect the fact that the front end of the CWS is driven by a series of decisions that are made from the point of original contact through the removal of children into the foster care system. This begins with someone’s decision of whether to make a hotline call. There are 3,987,000 calls alleging maltreatment made to the CWS on an annual basis, involving 7,176,600 individual children. From these calls, a decision is made to investigate these cases further: about 51.5 percent of reports are determined to include sufficient information to determine that an investigation is appropriate. The third decision addresses whether abuse or neglect has occurred: approximately 600,000 children are identified as having been abused or neglected. The next decision at the front end of the CWS is whether removal from the home is necessary. In 2021, approximately 207,000 children entered the system because a determination was made that removal was necessary. The final decision involves which services are appropriate, and these include services provided to children and families where children were removed from the home as well as children who are determined to be nonvictims of abuse and neglect who need services.

Figure 1. NCANDS Data, 2021

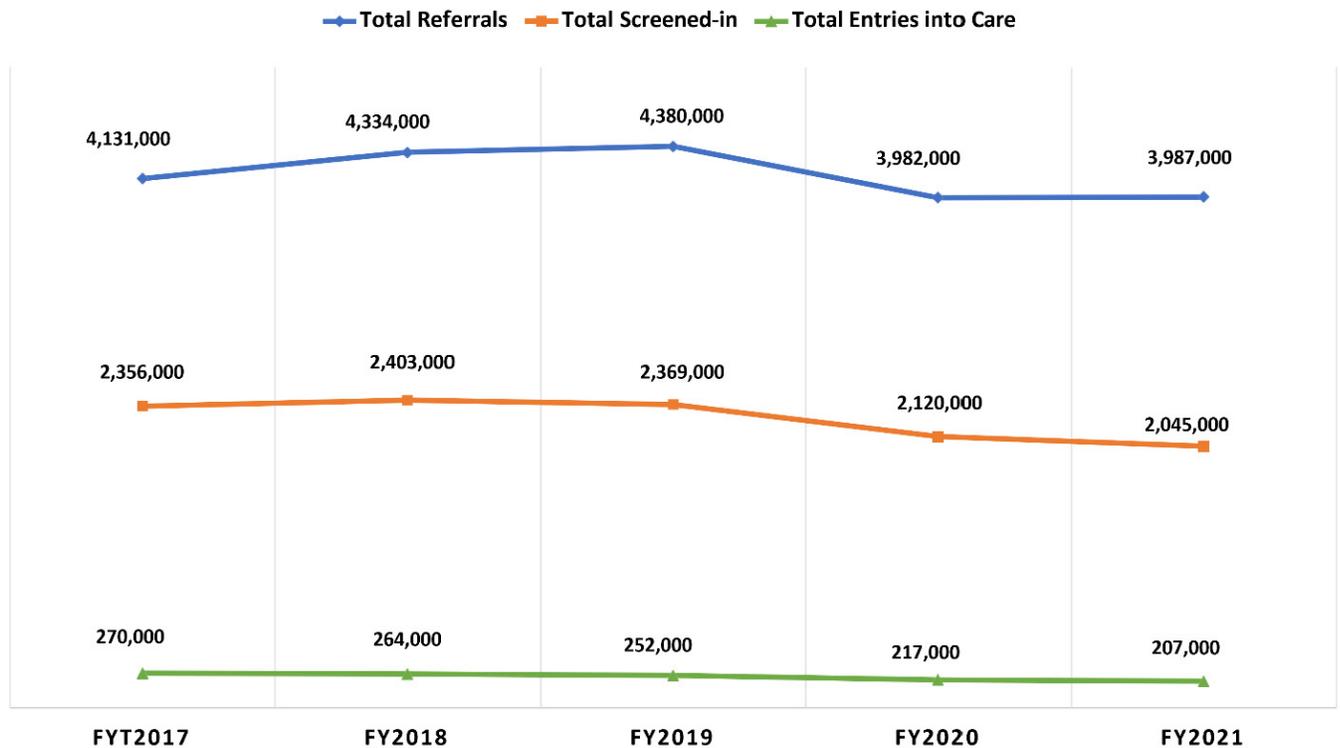


Figure 1 illustrates the total number of hotline calls that were made in blue. The population for which those calls were made was even greater than the numbers indicated by the blue line. The total number of children in the United States aged zero to 18 in 2021 was approximately 74 million, and the number of children for whom calls were made was 7,176,600, or nearly 10 percent. The orange line indicates the number of children for whom investigations were deemed necessary, and the green line represents the number of children for whom abuse or neglect was determined and entry into the system was necessary. Although in fiscal year (FY) 2021 the process began with nearly 4 million calls, only about 200,000 children were removed from the home. When looking at a 10-year period instead of this 5-year period, the numbers in 2012 were almost exactly the same as they were in 2021; however, the numbers did increase and then decrease during that 10-year period.

Examining the age distribution Adoption and Foster Care Analysis and Reporting System (AFCARS) data for children entering the foster care system in 2021 reveals that almost 21 percent were under the age of 1 year and that approximately 50 percent were between zero and 5 years old. A substantial proportion of children entering the CWS are at the younger end of the age spectrum. Interestingly, there are just as many 14- and 15-year-old

children entering care as there are 4- and 5-year-olds. Although the distribution of the total population of children entering foster care is skewed toward the younger end, it is not uniformly distinctly different among age groups, and it is important to consider this as well as different developmental stages when thinking about policy and research on intervention.

In terms of the race and ethnicity of the population that became involved in the CWS in 2021, AFCARS data indicate that 23 percent of families identified as White; 22 percent identified as Hispanic (any race); 22 percent identified as African-American; approximately 8 percent reported identifying as two or more races; 2 percent identified as American Indian/Alaska Native; 1 percent identified as Asian; and less than 1 percent identified as Native Hawaiian or other Pacific Islander. Of note, the number of Hispanic individuals was equal to the number of African-American individuals, which is not typically the narrative about what the CWS looks like; however, those two numbers are increasingly becoming very similar. The questions to ask are whether the system is prepared to respond to children of Hispanic heritage relative to children of color, whether the response is the same or different, and in what ways is the response different. When viewing the alignment of the numbers of African-Americans and Hispanics against the numbers over the past 10 years, it

becomes clear that this doesn't represent an increase in the number of Hispanics in the system; rather, it represents a continuing decline in the number of African-Americans entering the CWS. Ten years ago, there were 85,000 Hispanic children in out-of-home care. In 2021, there were 86,000 Hispanic children in out-of-home care.

There is much discussion about the circumstances associated with children's removal from the home. Well over 60 percent of removals occur because of a determination of neglect by the CWS. The second highest number of removals (over 35 percent) is associated with a determination of parental substance misuse, followed by approximately 12 percent associated with a determination of caretaker inability to cope, followed by approximately 11 percent associated with a determination of physical abuse. All other categories of circumstances are each associated with less than 10 percent of removals. Although physical abuse and sexual abuse are circumstances that have historically received a lot of attention, combined they represent less than 20 percent of total removals, raising the question of whether there are better ways of focusing on neglect to reduce the number of children entering the CWS. It is important to note that categories are not mutually exclusive: neglect may be co-occurring with other circumstances. Often, when thinking about neglect, people tend to think that solving the problem of poverty will solve the problem of neglect, but the overlap between categories (particularly neglect and parental substance misuse) and the underlying causes of neglect are important to keep in mind when considering the role of research. Clearly, incorporating into the FFPSA the decision to focus on parental substance misuse as a way of reducing parents' involvement in the CWA was in part based on these data, and the FFPSA is a good example of data-driven policymaking; from these data, it was clear that in order to make changes at the front end of the CWA, it would be necessary to address issues of substance misuse by parents.

Material hardship increases the risk of child welfare involvement. Neglect as a category is listed as the reason for 63 percent of child removals, and research has been working to break down neglect further to understand the underlying issues. Economics plays a role, and material hardship, defined as food, housing, utilities, and/or medical hardship, is associated with a higher risk for entry into the CWS.¹ Low-income families who experience at least one

material hardship are three times more likely to undergo an investigation for alleged neglect, and four times more likely to be investigated for allegations of physical abuse. Low-income families who experience multiple types of hardship after experiencing no prior hardships are four times more likely to be involved in a CWS investigation and seven times more likely to be investigated for allegations of physical abuse. The most reliable economic predictors of child welfare involvement for families are loss of income, cumulative material hardship, and housing hardship.² The FFPSA has created a lot of discussion around these issues, as well as a recognition that policymaking often involves picking "winners" and "losers." Unfortunately, in the 1950s and 1960s, a decision was made to separate the "safety net" programs from child welfare programs, as if they were unrelated to one another, so that dealing with abusive parents became the purview of one system and helping families dealing with economic hardships became the purview of another. In some ways, this has harmed the ability of these systems to respond appropriately to abuse and neglect, as the strongest predictors of investigated neglect reports are family food pantry use, cutting meals, short duration of residence, difficulty paying rent, utility shutoffs, inability to receive medical care for a sick family member, and public benefits receipt.³ Again, it is important to remember that neglect as a category overlaps significantly with other circumstances associated with child removal, and that reducing poverty and economic problems may reduce some removals associated with neglect, but there will likely remain a number of families with both substance use and neglect issues.

Mr. Samuels also noted that, as a former child welfare director, he feels that more exploration of the definition and reasons for neglect is needed. ASFA articulates how quickly someone must be sent to investigate a case and how quickly a determination of the outcome of that investigation must be made. The default circumstance identified as a reason for removal is neglect, when investigators must make a decision quickly and are not able to distinguish all factors suggesting removal. Neglect is the most obvious and easily determined circumstance. Further interrogation of the neglect category is important, but, for the purposes of the workshop, it is unambiguous

¹ Yang, M. Y. (2015). The effect of material hardship on child protective service involvement. *Child Abuse & Neglect*, 41(Mar), 113-125. <https://doi.org/10.1016/j.chiabu.2014.05.009>

² Conrad-Hiebner, A., & Byram, E. (2020). The temporal impact of economic insecurity on child maltreatment: A systematic review. *Trauma, Violence, & Abuse*, 21(1), 157-178. <https://doi.org/10.1177/1524838018756122>

³ Slack, K. S., Berger, L. M., DuMont, K., Yang, M. Y., Kim, B., Ehrhard-Dietzel, S., & Holl, J. L. (2011). Risk and protective factors for child neglect during early childhood: A cross-study comparison. *Children and Youth Services Review*, 33(8), 1354-1363. <https://doi.org/10.1016/j.childyouth.2011.04.024>

that substance use plays a role in the families who come to the attention of the CWS. There is a need to explore the overlapping circumstances of families, beginning with substance use and the role that it plays in removals.

Parents in Child Welfare (*Kimberly Nabarro & Crystal Hallock, Zero to Three*)

Dr. Jones Harden thanked Mr. Samuels for setting a tone and noted that most of the issues mentioned in his presentation would be explored further over the course of the workshop. She indicated that in the field of applied research, investigators are emphasizing the importance of community-based participatory research to elevate and focus on the voices of parents in the CWS. In that spirit, two parents that are part of the Zero to Three Safe Babies Project were asked to participate in the workshop. Safe Babies is a signature Zero to Three project that is focused on changing the trajectories of very young children in collaboration with the justice and CWSs. Ms. Hallock and Ms. Nabarro are parent leaders with the Zero to Three Safe Babies Project.

Ms. Nabarro (*Zero to Three*), joining the workshop virtually from the island of O’ahu in Hawaii, greeted meeting participants and explained that she is a Native Hawaiian birth mother and recovering methamphetamine addict. Ms. Nabarro has had child welfare involvement with six of her children, always related to her battle with perinatal SUD. During her pregnancies, she was also homeless and lacked any sense of identity beyond being an addict or her partner’s girlfriend. She was bonded to her partner and first became pregnant at 14 years old. Her first removal of a child occurred in 2003, and her last removal occurred in 2017. Her children who were removed at birth were placed outside of her care, and she did not successfully navigate the CWS and was never able to reunify with these four children. Today she raises the two children whom she was able to bring home from the hospital after birth, and she was able to breast feed these babies, connect, bond with, hold, and smell them. When she relapsed a few years after giving birth, she successfully navigated child welfare because of the bond and connection she had with these children.

Having an identity outside of addiction and believing that she was capable of being a good mother helped Ms. Nabarro and continues to help her today to stay the course and grow stronger as a parent to the two children she currently raises. She did not have these things when the

first four children were removed. At one time, she believed that addiction was all that she was good at. Finding her own strengths outside of the addiction and believing in them were essential, along with reconnecting to her culture as a Native Hawaiian, understanding what it means to be a Native Hawaiian, and finding ways to heal the community she comes from and, in turn, heal herself. The difference she sees between her early experiences with the CWS during the repeated removals and the present day is that she believes and can articulate and demonstrate that she is the best mother for her children. She currently serves as a parent leader consultant for Safe Babies, the network that serves as the Infant-Toddler Court Program National Research Center, and is a parent partner and a Makua Ally, locally. She walks alongside parents who are navigating the CWS, and works as a Makua (parent) Ally for the perinatal SUD population in the prevention of child welfare involvement through promoting stability factors, like enrollment in perinatal care, as well as teaching women to identify as mothers and to believe that they can be what is best for their babies. She also helps to prepare parents by providing information regarding the things the CWS will examine and the circumstances that will lead to removal, and she participates with parents to help them continue to engage appropriately with the system.

Today, Ms. Nabarro utilizes her own lived experience to connect with parents and to speak about her work and personal experience to help inform the CWS in making adjustments and changes to better support parents who are at risk of child welfare involvement or are already involved with the CWS. She feels that the relationships she has with herself, her children, and her natural and community supports have been instrumental in changing her self-image as a parent. Bonding and attachment to her children has had a tremendous impact on her ability to believe that she could be a good mother. In addiction, she ran away from things that did not make her feel good, as opposed to running toward things that did make her feel good, and the belief in her own parenting ability and decision to invest in becoming a good mother was a major factor in breaking that behavioral pattern. Knowledge and information have been very empowering. Learning about developmental stages, impacts, and pathways to self-empowerment so she could learn more about herself as a person, a parent, and an addict in recovery and learning about her children and ways that she can connect to them and help improve their lives were very important for her in making changes, and investing and believing in herself.

Crystal Hallock (Zero to Three)

Ms. Hallock greeted participants and indicated that she would be primarily sharing the story of her own experiences with the CWS. In 1994, she was 23 weeks pregnant with her daughter when she went into labor. At the hospital, it was suggested that she terminate the pregnancy, and Ms. Hallock refused, insisting that medical personnel do everything possible to save the baby. Her daughter was born weighing 1 pound, 3 ounces. Ms. Hallock was clean at the time of the birth but not throughout the pregnancy, and did not find out until several months after the birth that she and her daughter were incompatible blood types. She stated that this was one of the reasons she experienced preterm labor.

Ms. Hallock reported that when she visited her daughter in the neonatal intensive care unit (NICU) at the hospital, she received no support or encouragement from staff members. They all seemed very angry with her for giving birth to this child and admitting to having used during her pregnancy. It was very difficult to visit her daughter and deal with this; however, Ms. Hallock remained clean throughout her daughter's stay in the NICU. When it was safe for the baby to be held, Ms. Hallock was very excited; however, the nurses believed her to be under the influence and denied her the opportunity to hold her. At the time, Ms. Hallock's mother was also at the hospital, and Ms. Hallock asked her mother to please hold the baby, which was permitted. As it neared time for her daughter to be discharged from the NICU, Ms. Hallock was asked to stay overnight in the hospital for a few nights to demonstrate that she could care properly for the baby. The nurses felt that Ms. Hallock was not able to understand her daughter's special circumstances, and, although Ms. Hallock disagreed with this, a child welfare case was opened. Her daughter was placed immediately into a flex (preadoptive) home, and Ms. Hallock was allowed one visit per month. This was very difficult, because as the baby was growing and becoming more aware, she would cry and scream because she was being handed over to a stranger. Ms. Hallock felt that continuing to traumatize the baby in this way was not best for the child and elected to allow her to be adopted by her foster family. Although this was supposed to be an open adoption and Ms. Hallock was supposed to be allowed to communicate with her daughter, none of these conditions applied once the adoption was finalized. Ms. Hallock would see the child in the store with her adoptive parents and would hide around corners to have the opportunity to see her.

After this experience, Ms. Hallock descended into addiction and wrote a bad check, resulting in charges of forgery and a prison sentence. This was ultimately a blessing, because Ms. Hallock found out that she was approximately 2 weeks pregnant and was able to have a healthy baby. She spent 6 months in prison and returned to the father of the child upon release. They had three healthy children during their time together; however, the situation was domestically violent. Ms. Hallock reported that she remained clean for 5 years, but, because of domestic violence and the discovery that her husband had another child 2 days younger than their youngest child together, she relapsed. Her children were removed within 6 months of the relapse and placed with her sister-in-law; subsequently, her husband moved in with the children and his sister despite domestic violence charges filed against him. Ms. Hallock noted that the assessment worker assigned to her case at the time stated that she did not have to offer reunification services because of Ms. Hallock's prior case. Ms. Hallock fought this, and a permanency worker was assigned who guided her through family drug court, meeting with the judge, observing the court, and successfully progressing through the family drug court program. After this, Ms. Hallock was able to reunify with all three of her youngest children. She received support through the program and remained connected with the director of a small nonprofit organization. When a decision was made to create a position of "mentor mom" to bring more women in similar situations into family drug court, Ms. Hallock accepted this role. Since that pilot project 16 years ago, Ms. Hallock has transitioned from mentor mom for family drug court to a parent partner for the Safe Babies program, and she is now a parent leader for the Zero to Three program. She has now been clean for 21 years and is currently raising her three-year-old grandson.

Session I Questions

Dr. Jones Harden thanked both Ms. Nabarro and Ms. Hallock for their courage and willingness to speak at the workshop. She noted that their stories reinforce the importance of parent voices, not only with regard to substance use but also in terms of their experiences with the CWS, the supports they received, and what helped them to turn things around. She invited participants to share any questions they had for Mr. Samuels, Ms. Nabarro, and Ms. Hallock.

Cary Waubanascum, Ph.D. (*University of Wisconsin*) introduced herself as a social work educator. Noting that both Ms. Nabarro and Ms. Hallock had mentioned interacting with social workers in the CWS, she asked what the social workers could have done better to support Ms. Nabarro and Ms. Hallock.

- Ms. Hallock indicated that social workers could have been more supportive in their treatment of her, letting her know that she is human and an equal person. She stated that there is an attitude of superiority from the CWS and a lack of understanding that parents involved in the system make mistakes and have struggles. Support and trust that all parents “get it” at some point are needed. She noted that she has encountered parents who come to CWS who have had nine children and they finally get it on the ninth child. Social workers need to give parents the opportunity to start fresh every time and treat parents as humans.
- Ms. Nabarro suggested that it would be especially helpful if social workers would take time to keep up to date with supports that are available for parents and families in the community. Parents whose basic needs aren’t being met aren’t able to focus on anything beyond that, including parenting, and that is what is often perceived as lack of engagement or lack of belief in themselves. If social workers could keep up to date and share information about supports available to parents and demonstrate that they care about the parents and the things that are important to the parents and the parents’ success instead of only discussing the child welfare case, it would be very helpful.

Kelly Gurka, Ph.D. (*University of Florida*) followed up with the statement that Ms. Nabarro’s response appeared to underscore Mr. Samuels’ point regarding the divorce between the social safety net and the CWS and asked if any of the three panelists could comment.

- Mr. Samuels clarified that safety net programs are the federal government’s attempts to provide supports to assist the families who are marginalized, poor, or have other struggles, such as the Supplemental Nutrition Assistance Program (SNAP), Aid to Families with Dependent Children, and access to behavioral and mental health through Medicaid. He noted that the CWS and all of the safety net programs are a part of the Administration for Children and Families (ACF), so there is much opportunity to think about ways to move them together. Some of the safety net programs

see that one of their purposes is to prevent child abuse and neglect; unfortunately, most do not. Policy and practice in child welfare are driven by the premise that parents must earn the right to get their children back, and that is often translated to “without any help, you have to figure out how to get your act together or we don’t have any evidence that you’re committed.” In the context of substance misuse and mental health, relapses are assumed and mental health is a disease that needs to be treated on an ongoing basis, so it is reasonable to assume that families with these issues will struggle at different points of time. The CWS is not organized under the premise that these risks can be managed using evidence-based practices, which would allow child welfare to be more responsive to parents like the two who had just shared their stories.

- Ms. Nabarro stated that in active addiction, behavioral health and medical issues were not something she would think about, unless they were things that interfered with the ability to get high. Even completing an application for food stamps was nearly impossible for her when using substances. She began to pay attention to these issues because of being involved with the CWS. Her service plan, including the substance misuse treatment plan, provided the clarity to understand why it was important to take care of her mental and physical health. She noted that when she is working with pregnant women who are battling SUD, she finds that explaining to them why a resource is important is most helpful in convincing them to participate and commit. For example, helping mothers to understand that child welfare is not against them but that the purpose of the home visiting program is to see how safe and appropriate the mother can be as a caregiver is important. Explaining that by committing to substance use treatment, mothers will help to demonstrate that they are safe and appropriate caregivers because they are addressing their triggers and working to reduce their likelihood of relapse. Helping individuals to see the “why” behind each resource or requirement is essential to convincing anyone to use the resources or to believe that those resources could be beneficial for them.
 - Mr. Samuels noted that Ms. Nabarro’s comments are representative of child welfare’s understanding of how parents receive supports and what should be expected of parents. For a long time in the homelessness support systems, individuals were required to live in a shelter and

demonstrate that they were capable of a series of activities such as participating in substance misuse treatment, getting a job, etc., before housing would be provided. That field has learned through lots of research and evidence that those activities do not have to follow that sequence because stable housing is a foundation for achieving things like employment and other outcomes. Philosophically, the homeless support systems are recognizing that housing first facilitates positive change; housing is not a lever to force change. Child welfare still operates under a different kind of mental model regarding how to organize interventions for families. The CWS communicates that model to families, and families think that the CWS knows something about good parenting; therefore, the parent must figure out how to do a laundry list of things to be seen as a good parent. It is not necessary to subject families to this kind of coercion to see positive outcomes. That is the way the CWS operates, but there are other systems that do not treat people as if they must earn the right for services; rather, by providing those services in an integrated fashion, they increase the likelihood that all families will achieve better outcomes.

Dr. Gurka noted that Ms. Nabarro had answered her question perfectly.

Dr. Jones Harden relayed a question from the chat to Ms. Hallock, asking whether staff members in the NICU had explained what made them feel that Ms. Hallock wasn't capable of holding her baby, and whether the decision had been based solely on staff assumptions or whether the staff had been instructed to not allow Ms. Hallock to hold her baby.

- Ms. Hallock reported that admitting she had used substances during her pregnancy when she delivered her daughter had created a "red flag" for her daughter's case. When Ms. Hallock would visit and ask how her daughter was doing, the response was never positive, because she was so small and got down to 13 ounces during her hospital stay. When Ms. Hallock spent the night at the hospital, the staff believed that she was still using substances, although she had not used substances since her daughter was born. The staff claimed that she was not waking up to alarms, although she was, and that she was not properly changing diapers. Ms. Hallock feels that, although she understood how to care for her daughter, everything was stacked against her because of her admission to prenatal substance use. She noted that this happened in 1994, when drug addicts were

automatically considered bad people who were never going to change, and that as someone who comes from generational substance misuse, she already felt like a bad person.

Dr. Jones Harden relayed a question from the chat to Mr. Samuels, asking which systems or experiences contributed to the decline in the number of African-American children in the CWS he referenced during his presentation.

- Mr. Samuels reported that some, but not all, answers to that question are known. In 1997 at the time of ASFA, the child welfare population was made up of just over 500,000 children. Today, the population includes slightly less than 400,000 children. In 1997, approximately 200,000 of the 500,000 children were African-American, and today, only about 85,000 of the 400,000 children are African-American. While Mr. Samuels was working for the federal government, they looked at the geographical distribution of this decline and found that 10 states accounted for 80 percent in the reduction of African-American families involved in the CWS. The states themselves did not appear to have any other commonalities: there were as many red states as blue states, and they were not all grouped in one area of the country. Possibly the best explanation for the decline is the introduction of subsidized adoption and guardianship through ASFA. The focus on reducing the number of children in care since 1997 has been primarily on getting children to permanency faster and reducing the number of children in foster homes. Given that the number of African-American children in the CWS was so disproportionately large when ASFA was passed, they ultimately experienced a more significant change in the rate they were moving to permanency. If reducing the number of children in the CWS is the goal, progress has been made. However, if the only accomplishment is the reduction of the number of children in foster care and no other outcomes for these children are examined, this decrease is not necessarily indicative of a positive result for the children and families themselves. The drive for permanency and the initial disproportionality are probably the best explanation for the smaller numbers, but now it is important to move to a discussion of whether smaller is actually better and if not, what else is needed to achieve other kinds of outcomes like those related to well-being in this context.

Kristi Nolen, M.S. (*University of Florida*) thanked Ms. Navarro and Ms. Hallock for sharing their stories and asked whether the CWS now has checks and balances to prevent the types of bias and experiences that Ms. Hallock encountered, such as the monthly visits where she was not

able to bond with her child. Is the system actually doing a better job of making sure these types of things don't happen?

- Mr. Samuels stated that he doesn't know if the system is doing a better job or not. This could be unpacked further, but one obvious indicator that improvements have not been made is that children under 1 year old constitute the largest percentage of children removed from the home. This group is 20 percent of the entire population of children in the CWS. If children are being removed at that rate, it is hard to conclude that things have improved for new mothers. Policies move the population around by providing resources and incentivizing some outcomes over others, but it would not be unreasonable to conclude that there are continuing practices that are harmful in the same ways that Ms. Nabarro and Ms. Hallock have described, given the high number of removals for children under the age of 1.

(Name not provided) noted that Ms. Navarro had spoken about the ability to bond with her babies as a critical experience that drove her to successfully navigate the convoluted CWS. The FFPSA includes a section that has to do with early childhood court, and magistrates and judges are focusing on that age group. What they are doing in some areas is ensuring that the minimum visitation allowance of once per week is increased significantly so that bonding between parent and child can happen during a critical time period. Pilot projects are finding that in these cases, cases that result in successful reunification do not have later reentry into the CWS. Perhaps this is a glimmer of hope in the FFPSA's structure.

- Mr. Samuels agreed, stating that baby court is a wonderful example of taking a different approach with families with young children and that baby courts should be expanded wherever possible across the country.
 - Dr. Jones Harden noted that baby courts are being expanded and are currently in approximately 25 percent of U.S. states. More information is available on the Zero to Three website (<https://www.zerotothree.org/>). She also reported that visitation is the strongest predictor of reunification and is, therefore, important for both bonding and improving permanency.

Jessica Wisnowski, Ph.D. (*Children's Hospital, Los Angeles*), asked via chat what HBCD investigators and teams could do to convince parents who are not accustomed to participating in research to be a part of a big, long research project such as HBCD.

- Ms. Nabarro stated that transparency around how research data and information will be used and where it will go is very important, even if it feels like overcommunicating. She noted that when she led a pilot project working with a perinatal substance use population last year that is now a demonstration project, she saw women participating in the project because they wanted to help themselves, and they wanted to see the future of this population with shared experience and trauma experience a successful outcome. In her experience, investigators and research teams could be clearer in emphasizing that data are not being gathered from women to incriminate anyone or to be shared with individual case workers in any way, but are being collected to help improve knowledge and understanding of the population of women and children experiencing the same things. Including someone with lived experience who can work side by side with researchers to help decipher information could also help to lower defensive barriers. Compensation for the time parents spend participating in research is always helpful.
 - Ms. Hallock echoed Ms. Nabarro's statements, emphasizing that letting parents know that they could be a part of the change for the next individuals who go through these experiences is one of the aspects of research participation that is most enticing to families. It is also important, wherever possible, to make sure participants understand that their data will be associated with a number and not with their name and that information will be kept confidential. This will help relieve parental fears that if they share honestly, their data could result in another open case with the CWS.
 - Ms. Nabarro noted that when a mother has exposed her child to substances while pregnant, she is also constantly worrying that the child's behavior or development is due to that substance use. Explaining to parents that this research is a way to identify and understand the actual effects of substance use on their child, as well as that data can lead to reports and information dissemination to help others understand what is and isn't related to prenatal substance use and improve awareness of the long-term effects, could also motivate mothers to participate in HBCD.

Dr. Jones Harden thanked all three panelists for their willingness to participate in the workshop and for setting the tone for the rest of the day.

Session II: Overview of Child Welfare

(Keisher Highsmith, Dr. P.H., NIDA; Cara Kelly, Ph.D., Children's Bureau; Christine Fortunato, Ph.D., Office of Planning, Research, and Evaluation; Tamarie Willis, Ph.D., Office of Planning, Research, and Evaluation)

Joint Presentation: A Brief Overview of Policy, Practice, and Research Relevant to the Child Welfare System

Dr. Highsmith introduced colleagues Dr. Kelly, a Program Specialist with the U.S. Department of Health and Human Services (HHS) ACF Children's Bureau; Dr. Fortunato, Team Leader for Child Welfare Research, HHS ACF Office of Planning, Research, and Evaluation (OPRE); and Dr. Willis, Ph.D., Federal Executive Branch Policy Fellow, OPRE.

Dr. Kelly thanked participants and noted that she and her colleagues were excited to provide an overview of the CWS and the process for children and families as they are involved and move through the system.

Child Welfare Legislative History (Cara Kelly)

At its most basic level, the CWS is a group of interventions that are designed to promote the well-being of children by ensuring children's safety, achieving permanency, and strengthening families. The work of child welfare is carried out through both private and public partnerships; however, federal laws have a significant impact on how states and jurisdictions individually fund and deliver child protection, child welfare, and adoption programs. The Children's Bureau within HHS ACF holds the primary responsibility for implementing federal child and family legislation. The Children's Bureau works with state and local agencies to develop programs that focus on preventing child abuse and neglect by strengthening families, protecting children from further maltreatment, reuniting children safely with their families, and finding permanent families for children who cannot safely return home. More information about the Children's Bureau is available at <https://www.acf.hhs.gov/cb>.

Child welfare federal legislative policy outlines both child welfare funding and practice expectations. There are numerous important pieces of federal child welfare policy; however, a few are particularly important to understanding the functioning and funding of child protection systems.

First, the Social Security Act of 1935 authorized the first federal grants for child welfare services, which served as an impetus for states to establish child welfare agencies and to develop local programs to deliver child welfare services.

In 1974, the Child Abuse Prevention and Treatment Act (CAPTA) was enacted by Congress. CAPTA was the first major federal legislation addressing child abuse and neglect in the United States. In exchange for federal funding for child abuse prevention and treatment, CAPTA requires states to establish child abuse reporting procedures and investigation systems. The Indian Child Welfare Act (ICWA) was enacted shortly thereafter in 1978. Under ICWA, all child welfare court proceedings involving American Indian/Alaska Native children must be heard in tribal courts if possible, and tribes have the right to intervene in state court proceedings. ICWA also established specific guidelines for family reunification and placement of American Indian/Alaska Native children. In 1997, ASFA made the most significant changes to the child welfare provisions since they had been established in their current form in 1980 by the Adoption Assistance and Child Welfare Act. The key provisions of ASFA ensure that the safety, permanency, and well-being of children are prioritized in child welfare decision-making. CAPTA has been amended and reauthorized numerous times since 1974; however, an important amendment was made by the Comprehensive Addiction and Recovery Act of 2016 (CARA). CARA requires CWS notification of all infants identified as being affected by substance misuse, withdrawal symptoms resulting from prenatal drug exposure, or fetal alcohol spectrum disorder at birth and requires states to develop policies and procedures to address the needs of these infants and their families. Policies and procedures must require the development of a plan of safe care (POSC) to address the health and treatment needs of substance-exposed infants and affected family or caregivers. FFPSA significantly changed how services are provided for families and youth in the United States. In particular, it changed the role of community service providers, the way that courts advocate and make decisions for families, and the types of out-of-home placements available for youth.

While federal legislation sets umbrella guidance for state child welfare practice and funding, each state and jurisdiction have their own abilities to establish policies and procedures for their own CWS. This results in variation of policies and procedures across states and jurisdictions. Individual state statutes and policies vary from state to state on a variety of topics such as state or jurisdictional definitions of child abuse, neglect, and mandatory reporter; how the agency’s CWS infrastructure is developed, the level and type of funding available, and legal decision-making processes across the child welfare continuum. Additional information on variation in state statutes related to child welfare can be found on the State Child Abuse & Neglect (SCAN) Policies Database website (scanpoliciesdatabase.com). To date, there are two rounds of data available, which reflect the state definitions and policies in effect for the calendar years of 2019 and 2021. The data are organized into six variable domains, including:

1. Definitions of child abuse and neglect, with specifics regarding which states include prenatal exposure to drugs or alcohol in their definition of child abuse and neglect
2. Reporting policies
3. Policies related to screening in and screening out reports of abuse or neglect
4. Investigation policies
5. Child welfare responses
6. CWS context

The Public Child Welfare System (Cara Kelly)

Despite differences related to CWS development and infrastructure, there are some commonalities regarding how a family moves through the public CWS once initial contact is made. Public child welfare agencies provide four main sets of interventions—a child abuse and neglect hotline, investigation and family assessment response, foster care and in-home case management, and permanency. These interventions are distinct from one another, and the involvement of children and families differs as families become involved in various aspects of the CWS. Data from NCANDS and AFCARS for federal fiscal year (FFY) 2021 show that nearly 4 million referrals alleging abuse and neglect involving slightly more than 7 million children were received by child welfare agencies across the United States. Of those referrals, approximately

52 percent were screened in and became reports of abuse and neglect. The remaining 49 percent were screened out. Of the 52 percent that were screened in, 3,016,000 children and youth received intervention from the public child welfare agency in the form of either an investigation or a family assessment response. Of these children and youth, allegations of abuse and neglect were determined to be unsubstantiated or unfounded for approximately 80 percent, and allegations were determined to be substantiated or founded for the remaining 20 percent. As families become more deeply involved with the CWS, the number of children involved in various capacities decreases. For example, at a single point in time in 2021, there were 391,098 children in foster care. About 207,000 youth entered foster care in 2021, and 214,971 exited. Of children and youth who exited, just under half (47 percent) were reunified with their families, 25 percent were adopted, and 12 percent exited into guardianship. The smallest number of youth emancipated or aged out from foster care into independent living. These and other NCANDS and AFCARS data are available at the National Data Archive on Child Abuse and Neglect (NDACAN), at www.ndacan.acf.hhs.gov.

Typically, family involvement with the CWS touchpoint begins with first contact via the child abuse hotline, when child abuse and neglect are suspected by a member of the community. Each state and jurisdiction operate some form of a child abuse hotline, as required by CAPTA, to gather information regarding concerns of abuse and neglect. Some states have a state centralized child abuse hotline, and others have regionally specific hotlines. These hotlines are staffed 24-7 by trained professionals who collect information from the reporter regarding concerns of abuse or neglect and make decisions regarding whether the information meets statutory criteria in the state for the information to be screened in for further agency involvement or screened out. These decisions are typically made based on whether safety concerns are present regarding the alleged victim. When information does not meet criteria for future agency involvement, these cases are screened out and do not have any further formal public child welfare involvement. In many instances, these reporters are referred to external community resources to further support the family.

When allegations of abuse or neglect have been determined to meet state statutory criteria to be screened in for further child welfare agency involvement, a family can

experience one of two interventions from the child welfare agency, depending on the state system infrastructure. A family assessment may be performed in lieu of a traditional investigation for families determined to be at low or moderate risk. Approximately half of the states and jurisdictions in the United States have developed a family assessment response pathway in their child welfare infrastructure.

Decisions regarding whether a family receives a family assessment response or an investigation are usually based on factors such as the type and severity of the alleged maltreatment, the number and sources of previous reports, and the willingness of a family to participate in services. A family assessment differs from a traditional investigation in that the focus is on providing families with support, typically services and resources, to meet the needs that led to concerns for abuse and neglect. Because the focus of a family assessment response is on support rather than investigation, there is no official finding resulting from the allegations of abuse or neglect for the family. After services and supports are completed by the family in the family assessment response pathway, the family's formal involvement with the child welfare agency ends.

Allegations of abuse and neglect may also be responded to with a traditional investigation. Every state and jurisdiction CWS includes a process for traditional investigation of allegations. The purposes of this investigation are to learn if a child has been harmed or is at risk of harm, to reduce risk and increase safety for the child, to determine if a criminal action has occurred, and to assess the need for services to support the family. After an investigation has been completed, the child welfare agency makes a determination regarding the allegations of abuse or neglect. If the information gathered during an investigation supports a finding of child abuse or neglect, allegations are substantiated, and this finding is stored by the state in a central registry. Unsubstantiated reports result when information gathered does not support a finding of child abuse or neglect.

After an investigation is concluded, one of three actions may be taken. For the majority of families, children are determined to be safe in the home with no further need for Child Protective Services (CPS) involvement during the investigation, and the CWS case is closed. These families are often referred to other community supports outside of the child welfare agency to strengthen and

provide continued support to the family. A smaller number of families are referred to in-home case management. In these cases, an assessment is completed regarding the family's needs, and programs and services are identified to help support, strengthen, and stabilize the family. These families receive services in the home as well as on-going supervision and case management from the child welfare agency (in-home services). In-home services can include a wide range of interventions, and may be provided directly by the child welfare agency, by a practitioner that is contracted with the child welfare agency, or by a community organization or practitioner through referral. Community-based service referrals may be for services such as housing assistance, SUD treatment, or parenting education. Programs provided directly by the child welfare agency or through a contracted provider may include programs and services to support mental health, substance use, parenting education, or intensive family preservation services.

When the child welfare agency is involved with families and is providing support in an in-home capacity, the courts can sometimes become involved. Court involvement for families who are receiving services in the home typically occurs only when additional support, legal intervention, and oversight are necessary to ensure the safety of the children in the home. Families can remain involved with in-home services for as long as the family needs to work through its case plan goals; however, child welfare involvement in these cases tends to be more short term. In most cases, if a family successfully completes all programs and services in its case plan in order to address concerns identified during the investigation and assessment phase, the family's case with child welfare can be closed, and formal involvement will end.

In a small percentage of instances, a family's identified risks may increase to safety concerns despite the provision of services. In these situations, when it is determined that the child can no longer remain safely in the home with the family, a child may be removed from the home and placed in foster care. Despite public perception that most child abuse and neglect reports result in placement of the child in out-of-home care, the number of children placed into foster care represents a relatively small percentage of children who come into contact with the public CWS. When removal is necessary, children are placed in a variety of settings according to placement priorities established in federal legislation. Child welfare agencies

strive to place children with kin or relatives whenever possible when a child needs to enter foster care. When kin or relatives are not able to provide care for a child entering foster care, children are placed into licensed foster homes, with families who can meet their medical, behavioral health, educational, and social-emotional needs. In some instances, children entering foster care require a higher level of care and are placed in congregate care settings such as group homes or, in very rare instances, more restrictive facilities.

When children enter out-of-home care, the court becomes involved, and families receive legal representation as they work to reunify with their children. During this process, families receive on-going visitation with their children and participate in programs and services identified in the family's case plan that are designed to support the family in reunification efforts. These services are similar to the kinds of services received by families whose children remain in-home, and can include both community-based and agency-level interventions designed to address family needs that are related to the involvement of child welfare with the family. When children and youth are placed into foster care, it is imperative that child welfare agencies find safe, permanent homes for them as quickly as possible.

Permanency options for youth include reunification, adoption, guardianship, or a planned permanent living arrangement known commonly as independent living. Around half of children and youth placed in foster care are reunified with their families. The remainder experience adoption, guardianship, or, for some older youth, independent living. Adoption can occur by a relative or kin, the child's foster placement, or an adoptive parent, and adoption occurs after the termination of parental rights. Guardianship creates a legal relationship between a child and a caregiver that is intended to be permanent and self-sustaining and can provide a permanent family for the child without the necessity of terminating parental rights. Independent living may be an option for some older youth as they reach transition to adulthood, and these youth are provided a wide range of supports to prepare them for independent living.

When helping children and families achieve permanency, child welfare professionals must balance an array of issues, including needs of the child and the family, as well as legal requirements. In some cases, families may be experiencing issues such as substance use, mental illness,

or domestic violence, which may require the provision of complex services. Permanency can become challenging for families involved in other systems such as criminal or juvenile justice systems, which require additional layers of oversight and coordination. When these issues are present, the judicial system is involved to ensure that all legal processes, practice standards, and timelines are followed by the child welfare agency.

The optimal goal of the CWS is to close a case and end a family's involvement with the child welfare agency once permanency has been established and the family is stabilized. Prior to case closure, the child welfare agency ensures that adequate supports have been put into place to ensure long-term stability and support for the family, ultimately preventing future involvement with the child welfare agency. Additional information and resources related to the CWS are available on the Child Welfare Information Gateway website at <https://www.childwelfare.gov>.

Dr. Kelly introduced her colleague, Dr. Willis.

Child Welfare Research: Who Comes into Contact with the Child Welfare System? (Tamarie Willis)

Dr. Willis indicated that she would provide a brief overview of CWSs' administrative data at the federal level, followed by a discussion of ongoing research studies exploring variations in administrative data collection efforts at the state level.

The HHS ACF Children's Bureau possesses federal-level administrative data across the child welfare continuum, from referrals received by the child abuse hotline to data collected on youth aging out of foster care. In the area of prevention, the Children's Bureau collects information from states that choose to opt in to the voluntary Title IV-E Family First Prevention Program. These data are reported at the child level and include information on service provision, placement status, and basic demographic information. For families with formal involvement with the CWS, data are collected in NCANDS. NCANDS is a voluntary data collection effort for all states and jurisdictions across the United States. The information in NCANDS includes front-end system data related to referrals received, reports, substantiations, child fatalities, and services received by children and families. Once children enter out-of-home care, data

are collected in AFCARS, which includes case-level information on children who are in foster care and have been adopted. The AFCARS data include information related to demographics, reasons why children enter out-of-home care, and permanency outcomes. Finally, the National Youth in Transition Database gathers information from transition-aged youth. This effort includes data on independent living services received and targeted outcomes for these youth.

According to NCANDS data, the total number of referrals received by child welfare agencies increased between 2012 and 2019. Between 2019 and 2020, the total number of referrals decreased in nearly all 52 states and jurisdictions, and numbers did not significantly increase or decrease between 2020 and 2021. During the most recent FFY 2021 reporting period, 46 reporting states screened in 51.5 percent and screened out 48.5 percent of referrals received. Some children and families screened in received a traditional investigation, and others were transferred to an alternative response track. Children determined to be victims, where allegations received by the CWS were substantiated, were a small percentage of total referrals received and reports investigated: of the approximately 3 million children who received an investigation or alternative response in FFY 2021, approximately 600,000 children were identified as victims. Since 2012, the number of children determined to be victims has fluctuated,

including a peak in 2015, when 683,487 children were determined to be victims of child abuse and neglect. Since 2019, the number of children determined to be victims has continually decreased, and during the most recent reporting period in FFY 21, 51 states reported an estimated 600,000 victims and 2,416,000 nonvictims. During this same period, the majority of children determined to be victims were victims of neglect (76 percent), 16 percent were victims of physical abuse, 10 percent were victims of sexual abuse, and 0.2 percent were victims of sex trafficking. Of children determined to be victims, more than 50 percent of these children received post-response services. Children under 1 year of age consistently have the highest rate of victimization among all age groups.

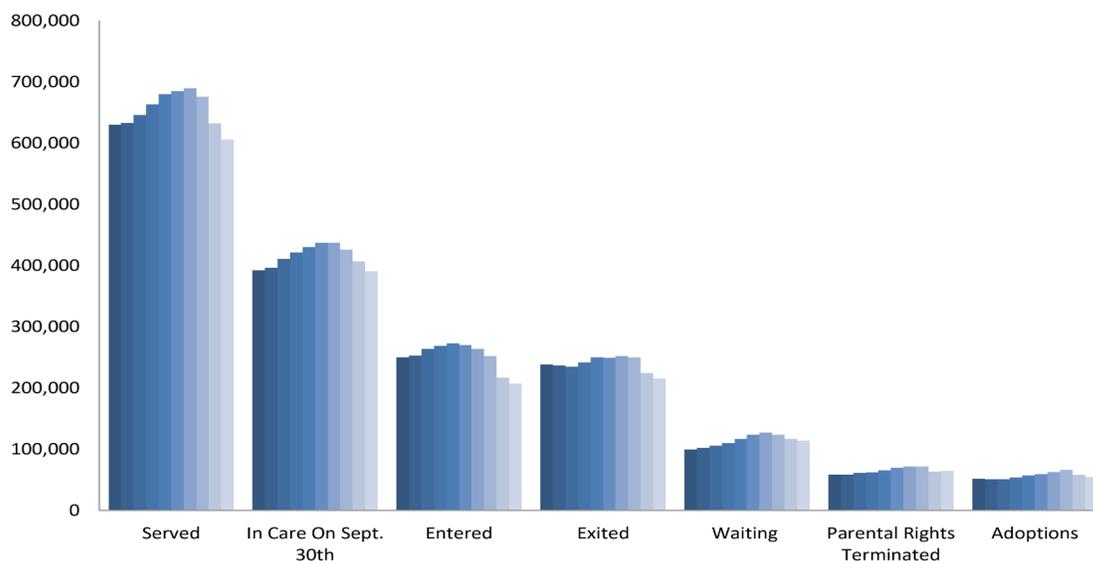
Over the last 10 years, the number of children in care rose approximately 11 percent, from a low of 392,000 in FFY 2012 to a peak of 437,000 in FFY 2017. Since FFY 2018, the numbers in care have been decreasing: the FFY 2019 total was 2.5 percent lower than the peak in FFY 2017, the decrease from FFY 2019 to FFY 2020 was 4.5 percent, and the FFY 2021 total decreased 3.9 percent from FFY 2020.

Figure 2⁴ provides a snapshot of the status of children in care as of FFY 2021, ranging from those who were served in any capacity to those who were adopted. These numbers represent a decrease in total children in care of more than 10.5 percent from 2017. The number of children exiting

Figure 2. Trends in Foster Care and Adoption: FY 2012-2021

(Based on data submitted by States as of June 28, 2022¹)

Source: AFCARS data, U.S. Children's Bureau, Administration for Children, Youth and Families



⁴ Source: U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau, <http://www.acf.hhs.gov/cb/data-research>.

from foster care during FFY 2021 represents a 14 percent decrease relative to FFY 2019; this is the lowest the total number of children exiting has been since the collection of AFCARS data began more than two decades ago. This is likely influenced by the decrease in the total number of children entering foster care, particularly for the last 3 years. Of the children exiting foster care in 2021, 47 percent were reunified with caregivers in FFY 2021, and 25 percent were adopted. The number of children waiting to be adopted includes children in care with a goal of adoption and/or with parents whose parental rights have been terminated, accounting for approximately 54 percent of the total number classified as “waiting.”

Parental Substance Misuse and Child Welfare Involvement

CARA includes an amendment to CAPTA to collect and report the number of infants with prenatal substance exposure (IPSE), IPSE with a POSC, and IPSE with a referral to appropriate services. Laws and/or policies in approximately 42 states and the District of Columbia require health care providers to notify CPS when they are involved in the delivery or care of infants who display evidence at birth of having been prenatally exposed to drugs, alcohol, or other controlled substances. A POSC is developed to ensure the safety and well-being of such infant following his or her release from the care of health care providers, including addressing the health and SUD treatment needs of the infants and affected family or caregivers.

NCANDS FFY 2021 data reveal that 49,194 infants in 49 states were referred to CPS agencies as infants with prenatal substance exposure, and approximately 83 percent of these infants were screened in for either an investigation or an alternative response. Of infants who were screened in, 70.4 percent had a POSC and 67.0 percent received a referral to appropriate services. Parental substance misuse also plays a significant role in the removal of children of all ages from the home. In FFY 2021, 36 percent of removals were associated with parental drug misuse, and 6 percent were associated with parental alcohol misuse. (Note: Parental drug and alcohol misuse categories are not mutually exclusive.)

Child Welfare Research

Recently, ACF has begun implementing efforts to better understand state-level administrative data and the promise of leveraging existing administrative data, innovative methods, and advanced statistical techniques to obtain more accurate and complete information on incidence rates of child abuse and neglect and related risk factors. The Child Maltreatment Incidence Data Linkages project was designed to explore how innovative administrative data linkages can improve understanding of child maltreatment incidence and related risk and protective factors. The ongoing State Child Welfare Data Linkages Descriptive Study is intended to provide novel information regarding state data linkages that may be leveraged to improve the ongoing and accurate surveillance of child maltreatment incidence and related risk. Extending beyond administrative data, The National Incidence Study (NIS) is a congressionally mandated, periodic research effort to assess the incidence of child abuse and neglect in the United States. Historically, the NIS included children who were investigated by CPS agencies, but additional data on children recognized as maltreated by community professionals (called sentinels), who were not reported to CPS or who were screened out by CPS without investigation, are also obtained. The NIS evaluates children submitted by sentinels and those described in CPS sampled cases according to standardized study definitions of abuse and neglect, and only children who meet definition criteria are used in generating national estimates. Data have been collected for four cycles, including 1979 and 1980 (NIS-1), 1986 (NIS-2), 1999 (NIS-3), and 2005-2006 (NIS-4).

The NIS and ACF research efforts provide important information on the scope of child abuse and neglect for those who come into contact with the CWS, as well as those who may never come into contact with the CWS. Many incidents are not reported to CPS, and few reported incidents are investigated and substantiated. In the depiction of an iceberg in Figure 3,⁵ reported cases are represented as the top of the child maltreatment “iceberg.” Even here, there are severe information gaps. Although NCANDS reports overall rates of screened out and unsubstantiated cases, child and family information is available only for substantiated cases in many states and localities, despite evidence of few differences in risk based on this designation.

⁵ Source: Adapted by Stagner et al. (2015). From Sedlak, A. J., *History of the national incidence study of child abuse and neglect*. Westat, Inc. 2001.

Figure 3. Child Abuse and Neglect Iceberg



The NIS collects data on children identified as maltreated but not reported through mandated reporters/sentinels, represented by the section of the iceberg just below the water line, but these data do not capture unreported cases known to the nonmandated half of potential reporters. Further down the iceberg, where cases are known to only alleged perpetrators and victims, incidence may be substantial but is likely underestimated because of a range of factors, including parents' reticence to admit abuse, the difficulty of asking children about maltreatment, and recall bias in retrospective surveys.

A significant body of research has documented the overrepresentation of certain racial and ethnic groups in the CWS relative to their representation in the general population. These racial disparities occur at nearly every major decision-making point along the child welfare continuum. African-American families are overrepresented in reports of suspected maltreatment and are subjected to CPS investigations at higher rates than other families. Further, African-American and American Indian or Alaska Native children are more likely to receive determinations of maltreatment, to be removed from the home, and to experience a termination of parental rights than other children. Relative to other children, African-American children spend more time in foster care and are less likely to reunify with their families. Compared with White children, they are less likely to receive services.

Factors that may contribute to racial disproportionality and disparity include, but are not limited to, individual bias and discrimination, CWS factors, geographic context, policy and legislation, and structural racism. More information on ACF-supported research programs can be found on the OPRE website at <https://www.acf.hhs.gov/opre>.

Experiences and Well-Being of Children and Families: Child Welfare Research

The National Survey of Child and Adolescent Well-Being (NSCAW) is the only source of nationally representative, firsthand information about the functioning and well-being, service needs, and service utilization of children and families who come to the attention of the U.S. CWS. Children are enrolled whether or not a case is substantiated. Information is collected about children's cognitive, social, emotional, behavioral, and adaptive functioning, as well as family and community factors that are likely to influence their functioning, and family service needs and service utilization. Children remain in the study, and data are collected at follow-up, whether or not they receive services.

Thus far, the study has included two cohorts with data collected directly from children and their caregivers, caseworkers, and teachers and indirectly through agency administrative records. Both cohorts have included children investigated for maltreatment during the sampling period, regardless of investigation outcome. NSCAW I included approximately 5,100 children from birth to 14 years of age, with five waves of data collection sampled from 1999 to 2007. NSCAW II included approximately 5,800 children, from birth to 17.5 years of age, with three waves of data collection sampled from 2008 to 2012. NSCAW III is currently underway. The current study maintains the design strengths of the previous two NSCAW cohorts while addressing the changing child welfare population and evolving policy and practice, such as the increasing use of differential response strategies. In addition to sampling children who have entered CWS custody through a maltreatment investigation, NSCAW III also includes a sample of children who have entered CWS custody for other reasons, such as involvement with the juvenile justice system and human trafficking. NSCAW III is also merging data from Medicaid claims with survey and agency data.

Baseline data collection for NSCAW III began in November 2017 and was completed in March 2022. Because of the in-person nature of data collection, baseline field work was paused during the coronavirus disease 2019 (COVID-19) pandemic from March 2020 until May 2021. Follow-up data collection is ongoing, with estimated completion by the end of 2024. Baseline data should be available at NDACAN this year, and the forthcoming data will be made available in the future.

Research from NSCAW I and II has provided a wealth of information with regard to the experiences of children and families involved in the CWS. More specifically, child welfare-involved children—whether they remain in the home, are placed outside of the home, or are discharged to permanence—are at higher risk for behavioral and developmental problems, compared with children in the general population.^{6,7} More than half of all children reported for child maltreatment had experienced four or more adverse childhood experiences (ACEs) by the time of contact with the CWS. These levels are extremely high; among the sample of adults interviewed for the Adverse Childhood Experiences Survey point of comparison, almost two-thirds experienced one or no ACEs. Even the youngest children in the NSCAW population have already accrued more adverse childhood experiences than most of the adults interviewed for the Adverse Childhood Experiences Survey.⁸

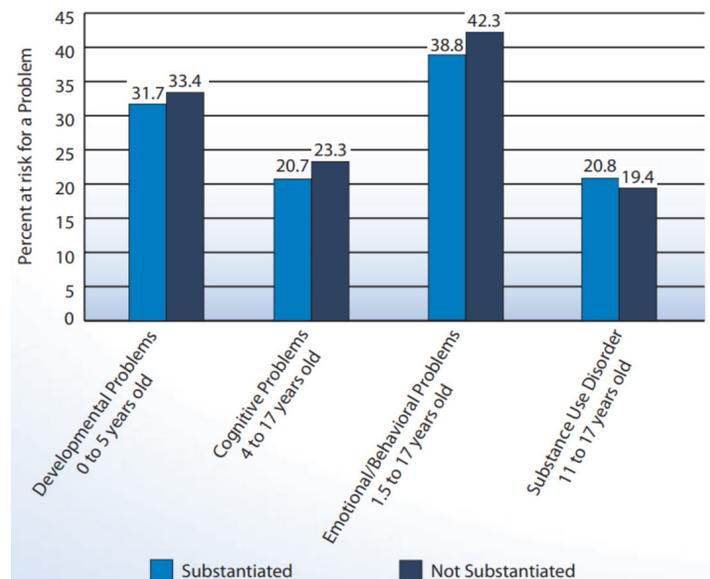
Over 85 percent of children who were infants at the time of the maltreatment investigation experienced at least one caregiver instability event during their first 2 years of life. Caregiver instability was associated with child chronic health conditions and the caregiver age of greater than 40 years at baseline.⁹ One quarter of parents whose children remained at home following a maltreatment report had experienced physical domestic violence during the previous 12 months. Among the same parents, investigative caseworkers identified active domestic violence for about 1 in 10.¹⁰ Voluntary kinship caregivers, who are in kinship care arrangements in which the child welfare agency is involved, but the state or tribe does not

have legal custody of the child, reported more financial struggles than formal kinship caregivers and nonrelative foster caregivers.¹¹

As illustrated in Figure 4,¹² the well-being needs of children involved with the CWS with and without substantiated cases of maltreatment do not significantly differ. Children with unsubstantiated reports of abuse or neglect are at a similar level of risk of negative outcomes as children with substantiated reports. Children in both groups are at risk for severe developmental and cognitive problems, as well as emotional or behavioral problems and SUDs.

This finding underscores the need for referrals and receipt of services to all children who come into contact with the CWS.

Figure 4. Well-being Needs of Children Involved with the CWS: NSCAW II



⁶ Burns, B. J., Phillips, S. D., Wagner, H. R., Barth, R. P., Kolko, D. J., Campbell, Y., & Landsverk, J. (2004). Mental health need and access to mental health services by youths involved with child welfare: A national survey. *Journal of the American Academy of Child & Adolescent Psychiatry*, 43(8), 960-970. <https://doi.org/10.1097/01.chi.0000127590.95585.65>

⁷ Casanueva, C. E., Cross, T. P., & Ringeisen, H. (2008). Developmental needs and individualized family service plans among infants and toddlers in the child welfare system. *Child Maltreatment*, 13(3), 245-258. <https://doi.org/10.1177/1077559508318397>

⁸ Stambaugh, L. F., Ringeisen, H., Casanueva, C. C., Tueller, S., Smith, K. E., & Dolan, M. (2013). *Adverse childhood experiences in NSCAW*. OPRE report #2013-26. Office of Planning, Research and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services.

⁹ Casanueva, C., Dozier, M., Tueller, S., Dolan, M., Smith, K., Webb, M. B., Westbrook, T., & Harden, B. J. (2014). Caregiver instability and early life changes among infants reported to the child welfare system. *Child Abuse & Neglect*, 38(3), 498-509. <https://doi.org/10.1016/j.chiabu.2013.07.016>

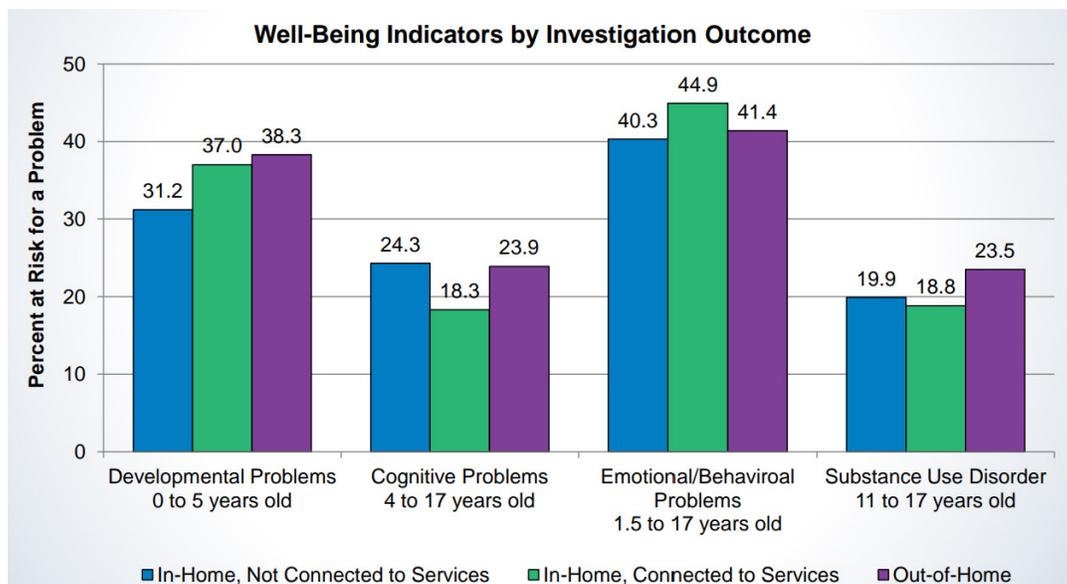
¹⁰ Casanueva, C., Ringeisen, H., Smith, K., & Dolan, M. (2013). *NSCAW child well-being spotlight: Parents reported for maltreatment experience high rates of domestic violence*. OPRE report #2013-04. Office of Planning, Research and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services. <https://www.acf.hhs.gov/opre/report/nscaw-child-well-being-spotlight-parents-reported-maltreatment-experience-high-rates>

NSCAW collects information about service needs, referrals, and receipt from caseworkers, caregivers, and children aged 11 years or older. Following a child abuse or neglect investigation, the CWS determines whether a child should remain in-home or be placed in out-of-home care, and/or if

¹¹ Casanueva, C. C., Smith, K. E., Ringeisen, H., Testa, M., Dolan, M., & Burfeind, C. (2023). *Services to support children involved with the child welfare system*. OPRE report #2023-039. Office of Planning, Research and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services.

¹² Source: Casanueva, C., Dolan, M., Smith, K., & Ringeisen, H. (2012). *NSCAW II child well-being spotlight: Children with substantiated and unsubstantiated reports of child maltreatment are at similar risk for poor outcomes*. OPRE Report #2012-31. Office of Planning, Research and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services. <https://www.acf.hhs.gov/opre/report/nscaw-ii-child-well-being-spotlight-children-substantiated-and-unsubstantiated-reports>

Figure 5. Risk of Outcome by Placement and Services Provided



the child and/or family should receive supportive services. These services may include an assigned caseworker, reunification services, child care, employment support, counseling, health and mental health referrals, SUD treatment referrals, transportation services, and many other types of services designed to support the needs of children and their families. Services are provided by CPS agencies, their partners, and other entities. Reasons for providing services may include preventing future instances of child maltreatment and remedying conditions that brought the children and their family to the attention of the agency.

Data from NSCAW II revealed that children placed in out-of-home care, such as foster care or kinship care and children who remain in-home shortly after a report of child abuse or neglect have similar and extensive service needs (Figure 5). NSCAW data suggest that children reported for maltreatment have a high risk of experiencing developmental problems, cognitive problems, behavioral/emotional problems, or SUDs, regardless of whether they were placed in out-of-home care, remained in-home with receipt of services, or remained in-home without services.

Only one significant difference was identified among the three groups: children ages 0 to 5 years old who were placed out of the home were more likely to have developmental problems than children who remained in-home and did not receive services. High needs are aggravated by a low rate of services received, particularly among those living at home after a maltreatment report

and among infants and toddlers.^{13,14} Among children with a condition that would potentially qualify them for Part B or C of the Individuals with Disabilities Education Act in out-of-home care including kinship and nonrelative kinship care, their caregivers reported in NSCAW II that half or fewer received Individualized Family Services Plan or individualized education plans services.¹⁵ Children 12 years or older placed in foster care are at particularly high risk for remaining in long-term foster care,¹⁶ and children living with kin caregivers are consistently less likely to receive needed services than children living in nonkin foster care. Voluntary kinship caregivers were less likely than formal kinship caregivers to receive Temporary Assistance for Needy Families (TANF). Both voluntary and formal kinship caregivers were less likely than nonrelative foster caregivers to receive peer support group and respite care services, and children in voluntary kinship care were less

¹³ Casanueva, C. E., Cross, T. P., & Ringeisen, H. (2008). Developmental needs and individualized family service plans among infants and toddlers in the child welfare system. *Child Maltreatment*, 13(3), 245-258. <https://doi.org/10.1177/1077559508318397>

¹⁴ Dolan, M., Casanueva, C., Smith, K., Lloyd, S., & Ringeisen, H. (2012). *NSCAW II wave 2 report: Caregiver health and services*. OPRE report #2012-58. Office of Planning, Research and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services. <https://www.acf.hhs.gov/opre/report/nscaw-ii-wave-2-report-caregiver-health-and-services>

¹⁵ Casanueva, C., Smith, K., Ringeisen, H., Dolan, M., Testa, M., & Burfeind, C. (2020). *NSCAW child well-being spotlight: Children living in kinship care and nonrelative foster care are unlikely to receive needed early intervention or special education services*. OPRE report #2020-31. Office of Planning, Research and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services. <https://www.acf.hhs.gov/opre/report/child-well-being-spotlight-children-living-kinship-care-and-nonrelative-foster-care-are>

¹⁶ Ringeisen, H., Tueller, S., Testa, M., Dolan, M., & Smith, K. (2013). *Risk of long-term foster care placement among children involved with the child welfare system*. OPRE report #2013-30. Office of Planning, Research and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services.

likely than children in formal kinship care and nonrelative foster care to receive support from the CWS to obtain immunizations, dental care, and Medicaid.^{10, 17, 18} More information about NSCAW is available on the NDACAN website at www.ndacan.acf.hhs.gov.

The FFPSA is an important component of child welfare in the United States and is part of a broader vision for changing child welfare practice at the national level. The legislation is comprehensive and accomplishes this goal in a few key ways. First, the legislation focuses on strengthening families and communities, and recognizes the importance of working with children and families to prevent unnecessary foster care placements. Next, the FFPSA focuses on the prevention of child maltreatment as a primary goal rather than foster care placement as the main intervention, and, importantly, it provides an opportunity for states and jurisdictions to envision and advance a vastly improved way of serving children and families. The legislation has requirements around the target population and type of services that can be received.

The Title IV-E Prevention Services Program legislation includes specifications of the target population and types of services that can be provided. A state or tribe may provide programs and services through the FFPSA to three categories of individuals: children who are candidates for foster care; children in foster care who are pregnant or parenting youth; and parents or kin caregivers of children in either of these two categories. Programs and services provided must relate to the categories of mental health and substance misuse prevention and treatment or to in-home parent skill-based programs such as parenting skills training, parent education, and individual and family counseling. All programs and services provided to a child or family must be provided under a framework that involves understanding, recognizing, and responding to the effects of trauma. More information on the Title IV-E Prevention Program is available at <https://www.acf.hhs.gov/cb/title-iv-e-prevention-program>.

¹⁷ Ringeisen, H., Casanueva, C., Smith, K., & Dolan, M. (2011). *NSCAW II baseline report: Children's services*. OPRE report #2011-27f. Office of Planning, Research and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services. <https://www.acf.hhs.gov/opre/report/nscaw-ii-baseline-report-childrens-services>

¹⁸ Casanueva, C., Stambaugh, L., Tueller, S., Dolan, M., & Smith, K. (2012). *NSCAW II wave 2 report: Children's services*. OPRE report #2012-59. Office of Planning, Research and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services. <https://www.acf.hhs.gov/opre/report/nscaw-ii-wave-2-report-childrens-services>

ACF established the Title IV-E Prevention Services Clearinghouse in accordance with the FFPSA to perform systematic reviews of research and evaluation on programs and services intended to provide enhanced support to children and families and prevent foster care placements. The Prevention Services Clearinghouse reviews and rates mental health prevention and treatment services, substance misuse prevention and treatment services, in-home parent skill-based programs, and kinship navigator programs. The Title IV-E Prevention Services Clearinghouse Handbook of Standards and Procedures includes unique standards and procedures developed in accordance with the statutory requirements detailed in the FFPSA; the handbook details the systematic review process used to identify and rate studies and to rate a program or service as well supported, supported, promising, or does not currently meet criteria.

The Prevention Services Clearinghouse website (<https://preventionservices.acf.hhs.gov>) is the primary way the clearinghouse disseminates information to the public. Visitors to the website can navigate through specific programs that have been rated on the “Find a program or service” page, learn about the clearinghouse standards and procedures on the “Review process” page, and access relevant resources on the “Resources” page. Users can access information about program or service implementation; specific studies reviewed, their eligibility, their design, and execution rating; findings from studies that met design and execution standards; and programs and services up next for systemic review. The website also provides frequently asked questions and information about the next programs and services planned for review. Visitors to the website can sign up for the clearinghouse’s email list to be notified of updates, including the availability of new ratings or resources.

To date, a majority of U.S. states have opted to participate in the optional Family First Prevention Program by submitting a Title IV-E prevention plan. The Children’s Bureau has approved 39 state plans and three tribal plans. Seven states, one jurisdiction, and one tribe have submitted plans that are currently under review, and five states have not yet submitted a plan; however, most states have expressed an intent to opt in to the program in the future.

ACF has recently published a Notice of Funding Opportunity entitled “Prevention Services Evaluation Partnerships: Building Evidence for Mental Health, Substance Use, In-home Parent Skill-based, and Kinship

Navigator Programs and Services.” The program will support 3-year grants for randomized controlled trials or quasi-experimental evaluations of a mental health, substance misuse prevention and/or treatment, in-home parent skill-based, or kinship navigator program or service. Awards will support collaborations among evaluators and partnering Title IV-E agencies, community entities, and/or other researchers for conducting well-designed and rigorous summative evaluations of programs and services intended to provide enhanced support to children and families—including pregnant and parenting youth in foster care—and to prevent child abuse, neglect and foster care placements. ACF is particularly interested in evaluations of programs and services designed or adapted for specific cultural, ethnic, or racial groups or programs and services targeting populations that have been historically marginalized and/or have historic or ongoing disproportionate representation in the CWS.

Session II Questions

Kim LeBlanc, Ph.D. (*NIDA*) noted that the timing of the decrease in victims seemed to overlap heavily with the COVID-19 pandemic, and she asked to what degree COVID-19 affected the decline relative to other factors.

- Dr. Kelly indicated that ACF has received varying information from different states across the United States, but that a number of jurisdictions had indicated, in the commentary section of their Child Treatment Report, their belief that the number of total reports and the subsequent number of victimizations were a result of the COVID-19 pandemic and decreased surveillance in the community. Since the pandemic has begun to ease, numbers are shifting slightly in the direction of their pre-COVID-19 levels, but have not returned completely to prepandemic levels. Anyone interested in learning more about individual state reports related to the COVID pandemic and administrative data can refer to *Child Maltreatment 2020*; Chapter 7 is dedicated entirely to analysis of the impact of the COVID-19 pandemic on child maltreatment data, and the final chapter of all Child Maltreatment reports is always dedicated to state commentary data. Here, it is possible to find additional contextual information from each state and jurisdiction regarding information they have provided to NCANDS that is presented in the Child Maltreatment report.

Alan Dettlaff, Ph.D. (*University of Houston*) reported, although the presentation of services provided by the CWS was thorough, he felt that the information was presented in a way that assumes that these services are neutral or benign, and did not include any mention of harm or trauma caused to children and families at every level of services. He asked Dr. Kelly how this information should be included in a presentation of all services, both in- and out-of-home services, offered by the CWS.

- Dr. Kelly indicated that when child assessments are completed in child welfare, case workers conduct a comprehensive review of all of the needs of the family to ensure that they’re connecting the family with appropriate supports and resources. When there is a housing need, or other resource-related concern that has been addressed by the case worker, the case worker refers the family to community supports. In other instances where the family need is more clinical in nature, like a substance misuse or mental health concern, the case worker provides referrals directly to specific services in the community to help address the issue.
 - Dr. Dettlaff indicated that he was referring primarily to the direct harm caused by the CWS, particularly as a result of forcibly separating children from their parents, which is well documented in research. He asked how the system responds to that.
- Dr. Kelly noted that, as Dr. Fortunato had mentioned during her presentation, the goal of the CWS is to keep children with their families, and there has been a strong administrative drive at ACF to focus on prevention in order to reduce the number of children who enter out-of-home care and the need for out-of-home placement. She noted that the best way she could address the question was that the CWS and child welfare agencies have begun in recent years to move toward prevention efforts in order to keep children in the home whenever possible.
 - Dr. Dettlaff asked how the system addresses the harm caused to children when it is necessary to remove them from the home.
 - » Dr. Fortunato noted that Dr. Kelly’s presentation was intended to focus on the process itself, but that the team appreciated Dr. Dettlaff’s question and looked forward to hearing more about some of the research on this topic.

Session III: Substance Use, Criminal Justice, & Child Welfare

(Mishka Terplan, M.D., M.P.H., Friends Research Institute; Rebecca J. Shlafer, Ph.D., University of Minnesota; Sean Couch, B.A.Sc., National Center on Substance Use and Child Welfare)

Dr. Highsmith introduced Dr. Terplan as the facilitator of Session III. Dr. Terplan is the Medical Director and Senior Research Scientist at Friends Research Institute and an adjunct faculty member at the University of California, San Francisco, where he is a Substance Use Warmline Clinician for the National Clinician Consultation Center. Dr. Terplan, in turn, introduced the Session III Panel, noting that the focus of this panel was on the intersection among substance use, criminal justice, and child welfare. Within this framework, Dr. Terplan's presentation centered on federal and state policies related to birth and on the role of health professionals in reporting to child welfare; Mr. Couch, Senior Program Associate in the National Center on Substance Use and Child Welfare, discussed state strategies with specific examples of POSCs as a way of operationalizing engagement; and Dr. Shlafer, Associate Professor at the University of Minnesota and expert on incarcerated women's health, discussed the intersection among substance use, criminal justice, and child welfare involvement among incarcerated individuals.

Support or Surveillance: Health Professionals, Carceral Complicity, and Birth (Mishka Terplan)

Dr. Terplan indicated that, during his presentation, he would focus on the interface between drug use and child welfare reporting, where drug policy collides with clinical care and research on SUD, specifically during birthing hospitalization, critically examining how the current heterogeneous landscape of criminal legal policies actually criminalize care of pregnant and parenting individuals who use drugs, as well as how the professional behavior of clinicians and researchers can further the oppression of already marginalized people.

The seminal work of reproductive justice emerged from the work of Black feminists in the 1980s, 1990s, and early 2000s, which identified a distinction between the aspirational nature of human rights, such as the right to reproductive health, and the reality that access to rights can be constrained. In this sense, reproductive justice is a framework for both analysis and action to realize aspirational rights. Reproductive rights not only include

the right to have a child or to not have a child but also the right to parent children in safe and healthy environments.¹⁹

Dr. Terplan noted that his talk was grounded in a series of assumptions, shared by most:

- Addiction is a chronic condition, treatment works, and recovery happens all the time.
- Child abuse (physical, sexual, emotional) is real, rare, and within health professional responsibility to assess and respond.
- Substance exposure (use of drugs while pregnant) is not in and of itself child abuse, and it is not clear that substance exposure during pregnancy is a risk factor for subsequent maltreatment or neglect.

CAPTA emerged from the ashes of the Comprehensive Child Development Act (CCDA), which was vetoed on December 9, 1971, by President Nixon despite having been passed by both chambers of Congress. The CCDA was a bipartisan effort to provide federally funded, universal, affordable early education and health care to all. The act would have supported reproductive rights and addressed the right to parent children in safe and healthy environments, and was widely supported by the American people. After the presidential veto, the CCDA was rewritten and shifted from a federal approach to comprehensively addressing child poverty to pathologizing poor families as potential child abusers. CAPTA in its original form did not refer to drugs or substance exposure; this was not added until the addition of "affected by" language in 2003. New language was developed to support a rapid response to potential child abuse and was built around a sense of urgency to assess and address child abuse, with aspects such as emergency petition hearings held to assess child safety within 72 hours of a notification. Although this makes sense in the context of children being sexually abused in the home, it is not necessarily appropriate in the context of a positive test for a cannabinoid metabolite, or a young mother recently prescribed buprenorphine for opioid use disorder.

¹⁹ Swislow, E. (2017). Activist Loretta Ross gives talk on reproductive justice. *The Amherst Student*, 147-8. <https://amherststudent.amherst.edu/article/2017/10/31/activist-loretta-ross-gives-talk-reproductive-justice.html#:~:text=Reproductive%20justice%2C%20she%20said%20in,Everyone%20should%20have%20that>

CAPTA also introduced mandatory reporting and a description of mandatory reporters that, in a way, prioritized reporting over treatment. In cases of substance use, this offset the responsibility for care of the chronic condition of addiction from the health professional to a surveillance agency. This also shifted the locus of care from health care spaces to CWS spaces; from individuals who may be trained in addiction treatment to individuals less knowledgeable in the areas of behavioral health and response. CAPTA specifies that states must have “policies and procedures (including appropriate referrals to child protection service systems and for other appropriate services) to address the needs of infants born with and identified as being *affected by substance abuse or withdrawal symptoms* resulting from prenatal drug exposure, or a Fetal Alcohol Spectrum Disorder, including *a requirement that health care providers* involved in the delivery or care of such infants notify the child protective services system of the occurrence of such condition in such infants”²⁰ (emphasis added). This language introduced substances into the paradigm of response to child abuse and has accelerated certain aspects of child entry into the CWS.

The average removal rate of infants in the CWS is 50 percent, relative to approximately 30 percent among older children. Infants represent the youngest age group in child welfare data, and reports and decision-making involving infants overwhelmingly refer to reports that originate during birthing hospitalization. Most reports for infants in the first year of life are driven by health professionals. Data from NCANDS²¹ indicate that although the number of reports for infants from families, anonymous schools, police, and others in the past decade has not changed, reports from health professionals have increased approximately 400 percent. This is likely driven by federal policy coupling drug use with child abuse. Racial inequities exist throughout the CWS and are especially notable in the rate of screened-in reports by medical professionals between 2010 and 2018, which reveal initial marked increases in reports involving American Indian/Alaska Native children, and more recently, an even more rapid rise in reports involving

Black infants. The CWS screened-in rate of infants for substance exposure, approximately 83 percent, is higher than the average screened-in rate (less than 50 percent), because many states have statutes that do not allow infants with positive substance use exposure screens to be screened out of the CWS.

When parental rights are terminated, a child’s birth certificate is rewritten. The birth mother’s name is removed and replaced with the adoptive mother’s name. Qualitative research literature comparing the behavioral and mental health burden of losing a child to death with that of losing a child through the termination of parental rights indicates that the mental health burden is greater for people whose parental rights are terminated. When a child dies, there is a social role for grieving parents, but there is no social role for parents whose rights have been terminated; their identity as parents has been erased in birth documentation.

Treatment and recovery journeys do not align neatly with the timeline of child welfare involvement. Recovery is “a dynamic process of self-directed action, it is the movement toward wellness, rather than any single outcome state ... ‘recovery’ [is] a process rather than an outcome. Abstinence, as one of many outcomes that may or may not fully occur across multiple domains of individual wellness, is thus a potential product of the process of recovery.”²² Recovery is a process, not an endpoint, yet Dr. Terplan feels that the CWS treats recovery as if it were a place, rather than a process. Abstinence is not the most important aspect to recovery. Recovery is about connection, community, purpose, and serenity, but Dr. Terplan believes that the CWS thinks abstinence is the core ingredient in recovery. This disconnect is an example of what can happen when decisions are made by individuals other than health professionals in collaboration with the people they serve.

States are markedly heterogeneous in the ways that they define the relationship between prenatal substance exposure and required reporting. In California, “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

²⁰ The Children’s Bureau. The Child Abuse Prevention and Treatment Act (CAPTA) with amendments made by the Substance Use-Disorder Prevention That Promotes Opioid Recovery and Treatment for Patients and Communities Act or the SUPPORT for Patients and Communities Act, Public Law (P.L.) 115-271, enacted October 24, 2018. Section 7065(a) of P.L. 115-271 amended section 105 of CAPTA, and section 7065(b) repealed the Abandoned Infants Assistance Act of 1988 (42 U.S.C. 5117aa et seq.). <https://www.acf.hhs.gov/sites/default/files/documents/cb/capta.pdf>

²¹ Edwards, F., Terplan, M., Roberts, S., & Raz, M. (under review). Data from Child Welfare Information Gateway (2020), <https://www.childwelfare.gov/pubs/factsheets/cpswork/>, and the American Academy of Pediatrics (2015), <https://pediatrics.aappublications.org/content/135/5/948>

²² Ashford, R. D., Brown, A., Brown, T., Callis, J., Cleveland, H. H., Eisenhart, E., Groover, H., Hayes, N., Johnston, T., Kimball, T., Manteuffel, B., McDaniel, J., Montgomery, L., Phillips, S., Polacek, M., Statman, M., & Whitney, J. (2019). Defining and operationalizing the phenomena of recovery: A working definition from the recovery science research collaborative. *Addiction Research & Theory*, 27(3), 179-188. <https://doi.org/10.1080/16066359.2018.1515352>

of the mother and child pursuant to [law]. 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 that 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" (§ 11165.13). In Michigan, "a person who is required to report suspected child abuse or neglect and who knows, or from the child's symptoms has reasonable cause to suspect, that a newborn infant has any amount of alcohol, a controlled substance, or a metabolite of a controlled substance in his or her body shall report to the department in the same manner as required of other reports. A report is not required under this section if the person knows that the alcohol, controlled substance, or metabolite, or the child's symptoms, are the result of medical treatment administered to the newborn infant or his or her mother." Georgia state law states that "the term 'prenatal abuse' means exposure to chronic or severe use of alcohol or the unlawful use of any controlled substance, as such term is defined in § 16-13-21, that results in either of the following:

- Symptoms of withdrawal in a newborn or the presence of a controlled substance or a metabolite thereof in a newborn's body, blood, urine, or meconium that is not the result of medical treatment
- Medically diagnosed and harmful effects in a newborn's physical appearance or functioning."

Mandatory reporting does not improve population health outcomes. Punitive state policies for drug use during pregnancy have been associated with increased odds of neonatal abstinence syndrome, low birth weight, and preterm delivery as well as decreased odds of any type of prenatal care, improvement in birth outcomes, and an Appearance, Pulse, Grimace, Activity, and Respiration (APGAR) score of 7 or higher.^{23, 24, 25, 26} As U.S. drug policy turns away from punitive drug policies, punitive policies

related to substance use during pregnancy are increasing.²⁷ This is due to increasingly restrictive reproductive health policies at the state level, specifically with regard to abortion. States that have restricted abortion access are more likely to treat maternal SUD as child abuse and are more likely to arrest, prosecute, and convict people using drugs for fetal demise and stillbirth. To support pregnant and parenting people with SUD, it is necessary to support reproductive autonomy and civil human rights.²⁸

Care is corrupted when linked to punishment. Mandatory reporting undermines clinical care through the generation of legitimate mistrust and contributes directly to provider moral injury. The American Society of Addiction Medicine's Public Policy Statement on Substance Use and Substance Use Disorder Among Pregnant and Postpartum People on October 2, 2022, declared that "equating a positive toxicology test with child abuse or neglect is scientifically inaccurate and inappropriate, and can lead to an unnecessarily punitive approach, which harms clinician-patient trust and persons' engagement with healthcare services."²⁹ Similarly, the American College of Obstetricians and Gynecologists' Opposition to Criminalization of Individuals During Pregnancy and the Postpartum Period: Statement of Policy asserted that "the laws, regulations, and policies that require health care practitioners and human service workers to respond to substance use and substance use disorder in a primarily punitive way, require health care providers to function as agents of law enforcement."³⁰ Although a fetus cannot distinguish between exposure resulting from prescribed medications used as directed or misused substances or between legal or illegal use or between natural substances and synthetic substances, provider assumptions equate social and legal distinctions with biological and public health. Prescribed medications, legal substances, and illegal substances can all cause harm to a fetus.

²³ Faherty, L. J., Heins, S., Kranz, A. M., Patrick, S. W., & Stein, B. D. (2022). Association between punitive policies and neonatal abstinence syndrome among Medicaid-insured infants in complex policy environments. *Addiction*, 117(1), 162-171. <https://doi.org/10.1111/add.15602>

²⁴ Thomas, S., Treffers, R., Berglas, N. F., Drabble, L., & Roberts, S. C.M. (2018). Drug use during pregnancy policies in the United States from 1970 to 2016. *Contemporary Drug Problems*, 45(4), 441-459.

²⁵ Carroll, J. J., El-Sabawi, T., & Ostrach, B. (2021). The harms of punishing substance use during pregnancy. *International Journal of Drug Policy*, 98, Article 103433. <https://doi.org/10.1016/j.drugpo.2021.103433>.

²⁶ Roberts, S. C. M., Thomas, S., Treffers, R., & Drabble, L. (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), 715-721. <https://doi.org/10.1093/alcalc/agx047>

²⁷ Roberts, S. C. M., Thomas, S., Treffers, R., & Drabble, L. (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), 715-721. <https://doi.org/10.1093/alcalc/agx047>

²⁸ Paltrow, L. M. (2002). The war on drugs and the war on abortion: Some initial thoughts on the connections, intersections and effects. *Reproductive Health Matters*, 10(19), 162-70. [https://doi.org/10.1016/S0968-8080\(02\)00013-7](https://doi.org/10.1016/S0968-8080(02)00013-7)

²⁹ American Society of Addiction Medicine. (2022, October 2). Public policy statement on substance use and substance use disorder among pregnant and postpartum people. <https://www.asam.org/advocacy/public-policy-statements/details/public-policy-statements/2022/10/12/substance-use-and-substance-use-disorder-among-pregnant-and-postpartum-people>

³⁰ American College of Obstetricians and Gynecologists. (2020). Opposition to criminalization of individuals during pregnancy and the postpartum period: Statement of policy. <https://www.acog.org/clinical-information/policy-and-position-statements/statements-of-policy/2020/opposition-criminalization-of-individuals-pregnancy-and-postpartum-period>.

Two very large knowledge gaps exist in the current understanding of prenatal substance exposure and its impact on infants and children. More is known about exposure at the time of birth than about timing, frequency, or amount of substance use during pregnancy. Prospective cohort studies typically focus on substance exposure without distinguishing between treated versus untreated parental SUD or without measuring children’s recovery, resilience, or frequency of interactions with the CWS. When research focuses on brain outcomes of prenatal substance exposure, it generally does not address exposures that can happen after birth. Further, more is known about infant sensorimotor tasks in the first 2 years of life, something that lacks predictive validity for later cognition, than is known about social function, sense of self-worth, or connectedness to others or society.

Figure 6. Knowledge Gaps in Research on Prenatal Substance Exposure and Brain Outcomes



A 2008 study of the association between prenatal exposure to marijuana, cocaine, opiates, heavy smoking (10 or more cigarettes per day) and heavy drinking revealed that, although unadjusted, multivariable regression analyses indicated that all types of prenatal substance use were significantly associated with low birth weight. However, when analyses were adjusted for social (maternal age, money for necessities, housing), psychosocial (stress, pregnancy locus of control), behavioral (early prenatal care), and biomedical factors (hypertensive and other medical disorders, prepregnancy weight, net weight gain), only heavy smoking was significantly related to low birth weight.³¹

³¹ Schempf, A. H., & Strobino, D. M. (2008). Illicit drug use and adverse birth outcomes: Is it drugs or context? *Journal of Urban Health: Bulletin of the New York Academy of Medicine*, 85(6), <https://doi.org/10.1007/s11524-008-9315-6>

Dr. Terplan noted that state policies related to child welfare reporting for substance exposure interfere with clinical care, biomedical research, and patient safety. HBCD is an incredible study whose design allows for nuanced prospective assessment of development contrasting infants with and without substance exposure, rather than only examining cases where there is an effect. HBCD is also designed to provide data regarding the magnitude and possible pathways of an effect of fetal exposure on brain development with standardized research protocols. However, a conflict exists between the scientific questions asked by the HBCD study and the social environment where the research is being conducted: the trial is unfolding across a heterogeneous landscape where reporting policies and practices often assume harm. Questions for further consideration include:

- Is a “child abuse” response to substance use/addiction during pregnancy/parenting a public health or social justice issue?
- Are we studying the effect of substance exposure on development, the effect of drug (and reproductive health) policy on development, or both?
- Do state policies interfere with critical data collection for HBCD? If so, what are the opportunities for solutions?

The Intersection of Substance Use and Child Welfare: How States Are Responding and How You Can Engage These Systems to Improve Outcomes for Families (Sean Couch)

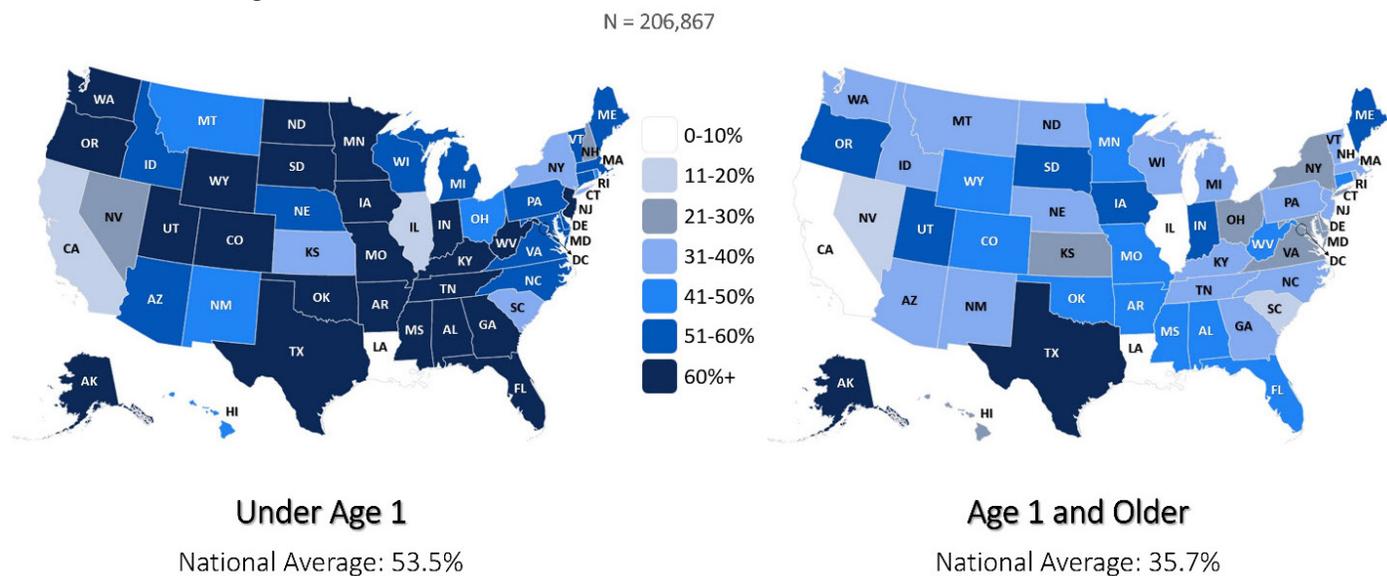
Mr. Couch provided a brief background for the National Center on Substance Abuse and Child Welfare (NCSACW), launched in 2002, and discussed state responses to the intersection of substance use and child welfare, the role of the Family Care Plan (FCP)/POSC, and ways to engage systems to improve outcomes for families.

NCSACW represents a collaboration between the ACF Children’s Bureau and the Substance Abuse and Mental Health Services Administration (SAMHSA). The goal of NCSACW is to provide resources to states and jurisdictions to help them improve outcomes for the families they serve. The center provides collaborative

technical assistance and can be considered a Technical Assistance Resource Center. NCSACW disseminates content on a regular basis, including content to aid in research. The center also offers trainings with national experts, technical assistance to regional partnership grants, and a 2-year in-depth technical assistance process that provides direct support to sites and helps them to implement programs or initiatives aimed at improving outcomes for infants born to substance users. In-depth technical assistance is tailored to the needs of each site, and may include helping sites to implement a POSC within their states or helping them to move the POSC upstream for implementation during the prenatal period. The NCSACW also holds a policy academy that brings together sites from across the nation in order to equip them to accomplish goals they have set for families affected by parental substance use and infants born with prenatal exposure to substances.

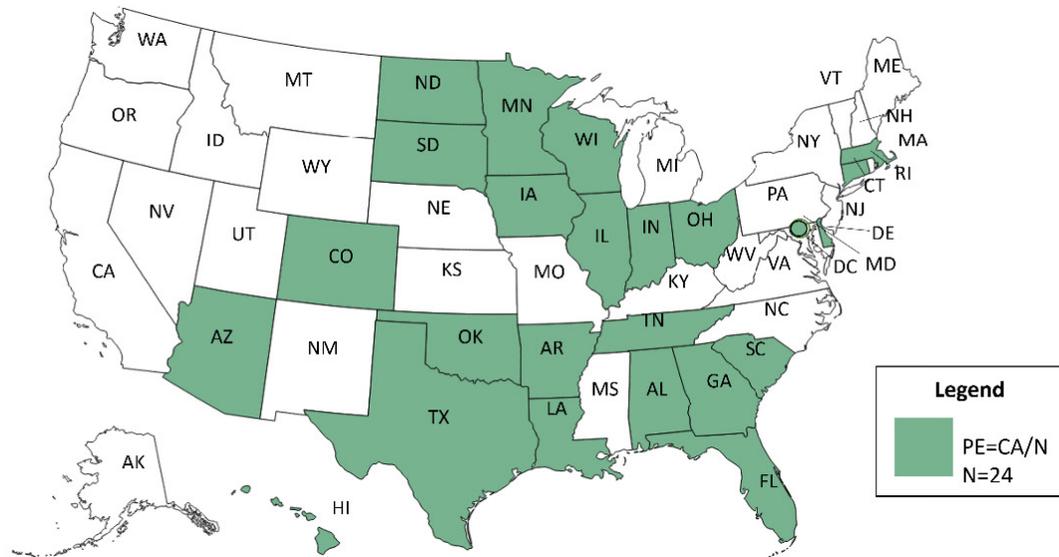
AFCARS data regarding the incidence of parental alcohol or drug misuse as an identified condition of removal in the United States indicate that in 2021, nearly 40 percent of children removed from the home had parental alcohol or drug misuse listed as one of the reasons for the removal. In 2021, 206,867 children entered out-of-home care, including 80,880 with parental alcohol or drug misuse as an identified condition of removal. A majority of these children (54 percent) were less than 1 year old. Figure 7 illustrates the distribution of these cases across the United States in 2021. While differences between states are likely related to differences in state data reporting approaches, a child welfare worker anywhere in the United States will report that alcohol or substance use is involved in upwards of 70 percent of families he or she serves.

Figure 7. Incidence of Parental Alcohol and Drug Misuse as an Identified Condition of Removal for Children by Age, 2021³²



³² AFCARS Data, 2021, v.1.

Figure 8. States That Equate Prenatal Exposure (PE) with Child Abuse or Neglect (CA/N) in 2022



States are responding to these numbers in different ways. About half of states no longer define prenatal substance exposure alone as child abuse or neglect (Figure 8).³³ In New Mexico, the 2019 House Bill 230 amended statutes for reporting to clearly state that “a report of child abuse or neglect shall not be made solely on the finding that a pregnant woman has used or abused drugs” and that “all New Mexicans are still required to report a reasonable suspicion that a child is an abused or neglected child based on other criteria or combination of criteria.”

However, these states do not necessarily report better outcomes about neonatal abstinence syndrome or infant removal. It is likely that infant removal rates are driven by local practice and actual implementation of policy related to a lack of clear guidance as to how state policy should be implemented.

Some states now require a notification to child welfare instead of a report of suspected child maltreatment for infants born affected by substances but without risk or safety concerns. Rhode Island has provided detailed guidance for practitioners, specifying when a report to CPS is necessary, such as when a newborn is diagnosed with fetal alcohol spectrum disorder, and when a CAPTA notification should be made, as in a case where a mother is engaged in medication-assisted treatment (MAT) with methadone or buprenorphine and there are no safety concerns. Notifications do not include any identifying information, do not result in child welfare investigations,

and are made for the purposes of public health surveillance and allocation of resources to areas where they are most needed. In contrast, reports of alleged child abuse or neglect do result in an investigation and potential removal of the child or criminal action against the birthing individual or parent.

NCSACW has worked with states that have created distinct CAPTA notification pathways for families with a lower risk profile, which allows for the provision of a POSC for families who may not need child welfare intervention. Currently, many infants with prenatal substance exposure receive an automatic investigation or assessment from child welfare. Some of these are closed after an initial investigation with services recommended to families, but many families do not engage in services and there is no provider charged with monitoring or follow-up. With the CAPTA notification pathway for families with no safety or risk concerns, a POSC is developed, and families are engaged and monitored by a community partner. In CAPTA notification cases in Nebraska, after hospital providers determine that a notification is appropriate, a POSC is developed by the hospital, which then sends the POSC to the infant and mother’s primary care physician and sends the notification form to Children’s Services. Many states have their own versions of this pathway to ensure that those with no safety or risk concerns who could still benefit from services are able to access these in their community through a POSC.

³³ Source: Center for Children and Family Futures (2022).

To develop a CAPTA notification pathway, stakeholder engagement and buy-in across systems, especially the CWS, are critical. Child welfare agencies can help communities distinguish between prenatal exposure alone and exposure accompanied by child safety concerns and risk factors and collaborate with providers and community supports to develop guidance, as was done in Rhode Island. This collaborative effort also helps to increase buy-in to the alternative notification pathway from the medical community. The notification pathway also allows communities to target services and supports more precisely to prevent child welfare involvement while meeting the needs of families.

States are also moving POSCs further upstream by implementing these plans during the prenatal period. NCSACW has worked with many sites to expand their focus and support families in the prenatal period in order to enhance family well-being and protective capacities prior to birth. This enables a mother or pregnant individual to obtain concrete supports and expand support connections well in advance of the highly vulnerable time of the birth event, as well as to develop a network of recovery support and an improved understanding of infant social and emotional development. NCSACW found that creating a prenatal POSC reduces the need for child welfare involvement or family separation and, ultimately, results in better outcomes for the infant and family. Many states use a binder model, with an actual physical binder containing the POSC, support resources, and planners to track appointments. This binder serves as a “recovery résumé,” detailing the pregnant individual’s efforts and progress that can be shared with the CWS if contact is necessary at or after birth.

Prenatal POSCs or FCPs are not required by CAPTA, but are considered a supportive, preventative practice. In Oklahoma, the implementation of POSCs during the prenatal period has resulted in multiple positive outcomes. In Tulsa, infants with neonatal abstinence syndrome born prior to the implementation of the FCP received immediate pharmacological interventions, stayed in the NICU for an average of 90 days, and were placed in out-of-home foster care for an average of 1 year. In the first 2 years of FCP implementation, 50 infants received an FCP. None of these 50 infants required pharmacological intervention or an NICU stay, and all went home with the parent. Oklahoma City established Oklahoma’s first Substance

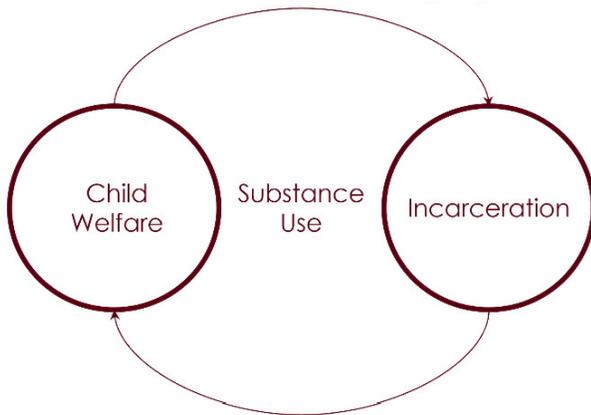
use, Treatment, And Recovery (STAR) clinic to provide both prenatal and SUD care in a single location, where an FCP was provided to each pregnant individual. Of these families with an FCP, 89 percent were able to bring home their infant after being discharged from the hospital after birth, and in Okmulgee, 91 percent of infants born to families with an FCP were able to go home with a parent after hospital discharge.

Researchers and members of the public can get involved with NCSACW and related systems by learning about prenatal exposure policies in their own states and communities. NCSACW has access to state data and will share information upon request. Scientists can also partner with state child welfare and substance use treatment agencies to discuss how ongoing research can influence policy and practice improvements, engage with state Perinatal Quality Collaboratives, and seek input from state hospital associations and state medical associations. Building relationships and connecting with people involved in these systems are key to understanding their goals and priorities and the ways that research can contribute to these. While different people and systems have different immediate priorities, all want to improve outcomes for families.

Maternal Substance Use, Criminal Justice, and Child Welfare Involvement: Intersections and Implications *(Rebecca J. Schlafer)*

Dr. Schlafer introduced herself, noting that she is a developmental child psychologist with training in maternal and child public health. She was a guardian ad litem for the fourth judicial district in Minnesota for more than a decade. She has also worked with children and families affected by incarceration for more than 15 years and is the research director for the Minnesota Prison Doula Project (MPDD). The MPDD is a community-based organization that initially provided pregnancy and parenting support to pregnant people at a women’s prison and has expanded to county jails across Minnesota. The project has also recently contracted with the Federal Bureau of Prisons to provide services in federal prisons. As part of the MPDD project, Dr. Schlafer leads a multisite study of enhanced perinatal programs for people in prison. Eight years ago, Dr. Schlafer and her husband became kinship foster parents after her sister-in-law was involved in a drunk-driving incident and subsequently adopted all

Figure 9. Bidirectional Model of Involvement with the CWS and Criminal/Legal System in a Context of Substance Use



three children, now 13, 14, and 15 years of age. Each of these factors contributes to a unique perspective on the carcero-legal and CWSs.

The intersection of the criminal/legal system with issues of substance misuse and child welfare involvement can occur in a number of different ways. Substance use may lead to child welfare involvement and, later, incarceration. The criminalization of substance use can also lead to a period of incarceration that, in turn, can lead to a disruption of child well-being and child welfare involvement. However, substance use can also lead to co-occurring incarceration and involvement of the CWS when pregnant people using substances are forcibly put behind bars. What is likely happening for many families involved with both systems is an intersecting, bidirectional influence on both child welfare and criminal/legal system involvement against the backdrop of substance use, illustrated in Figure 9. Within this model, it is very likely that other factors, such as mental health, housing insecurity, economic instability, and other social determinants of health, are also determinants of risk of CWS and criminal/legal system involvement. It is very challenging to deconstruct the intersections of these factors, as data are limited to cross-sectional points in time. It is also difficult to place these factors on a timeline or assign causality when, for most families, there are multiple co-occurring issues and involvement with the criminal/legal system often occurs over a life course. Similarly, CWS involvement does not occur at a single point in time and may include cycles of removal, reunification, and removal.

As a guardian ad litem, Dr. Shlafer watched children and families move through these systems, and worked with companion child welfare/criminal cases where court hearings were held one block away from one another and judges made drastically different decisions about the same family. This system requiring parents to attend court hearings in two locations and provide urinalysis screens for two different sets of judges was extremely inefficient and harmful for children and families. This issue was summarized by Susan Arding, founding member of the San Francisco Children of Incarcerated Parents Initiative and supervising social worker for the San Francisco Human Services Agency:

"I've been a social worker for a long time, and it's heartbreaking when I see our kids grow up in foster care and go from group home, to juvenile hall, to jail, and then to prison. And then, I see their children come into the foster care system, and the generational cycle starts again. The corrections and child welfare system are two complicated bureaucracies, often serving the same families, but each operating on different timelines, different rules, different funding. If corrections and child welfare put our collective resources together, perhaps we can stop this cruel, vicious cycle."

Many systemic inequities have resulted in marked disparities in the U.S. incarcerated population. Dr. Schlafer believes that structural racism and racist practices and policies have led to the incarceration of women of color at disproportionately high rates. In 2021, the imprisonment rate for Black women was 1.6 times that of White women, and Latina women were imprisoned at 1.3 times the rate of White women. In Minnesota, Native American women make up less than 1 percent of the state population but make up 20 percent of the women in Minnesota state prisons. At the intersection of incarceration and child welfare involvement, where children have been forcibly separated from families for generations, Dr. Shlafer feels that racist policies and practices have stripped families and pulled them apart.

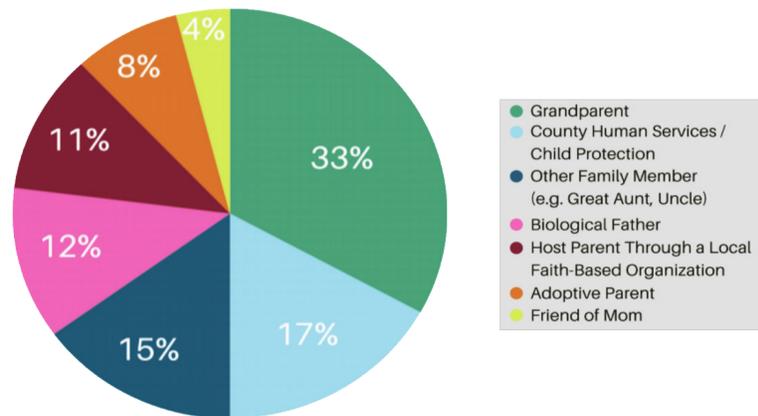
Most incarcerated women are of childbearing age, and a majority are mothers with minor children. Women in prison experience very high rates of chronic health conditions and mental health issues. Compared with men, women’s pathways to prison include disproportionately high rates of mental illness, substance use, trauma, and sexual victimization. A set of self-reported adverse childhood experiences (ACEs) data from adults currently incarcerated in state prison has revealed that parents report significantly more ACEs (approximately four ACEs) than nonparents (approximately three ACEs), and mothers average significantly more ACEs (four to five ACEs) than fathers (approximately three ACEs).³⁴ Among adults who provided ACEs data, 29 percent of mothers and 17 percent of fathers reported having had their parental rights terminated for one or more of their children, and for both mothers and fathers, higher numbers of self-reported ACEs were significantly associated with higher odds of having parental rights terminated. Termination is a very specific and serious consequence of child welfare involvement, and the significant association of termination with parental ACEs is illustrative of generational trauma. The data also suggest that highly traumatized people have been incarcerated, and as interventions, child welfare involvement and incarceration are not meeting the needs of these people with regard to trauma or SUD. At the intersection of substance use and incarceration, very high rates of SUD (according to *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* criteria) were identified among female state prison inmates for alcohol (~30 percent), cocaine (about 30 percent), marijuana (about 16 percent), stimulants (about 24 percent), and heroin (about 10 percent) in 2012.³⁵

Many U.S. prisons do not systematically collect data or screen for pregnancy. Dr. Schlafer has heard repeatedly from jail administrators that this is because positive pregnancy screens require jails and prisons to provide prenatal care, and prenatal care is expensive. The Pregnancy in Prison Statistics study examined data from 22 state prisons, six large jails, and the federal prison system, and determined that 4 percent of females entering state prison were pregnant, and approximately 3,000 pregnant individuals were admitted to U.S. prisons each year. The same study revealed that 3 percent

of females entering jails were pregnant, equating to approximately 55,000 admissions of pregnant people to U.S. jails each year.^{36, 37}

Pregnancy in prison is characterized by a lack of supportive policies and practices. Prisons and jails are not designed to support pregnant and parenting people. Dr. Schlafer believes that these systems will never be safe or supportive for pregnant people. Most jails do not screen for pregnancy, and many pregnant individuals enter incarceration facilities unaware that they are pregnant and do not get basic care. There are no mandatory standards for pregnancy-related care in prisons; there are some voluntary guidelines, but very little oversight to determine whether standards are met. Pregnancy-related care in prison is consistently described as poor, and most states do not ensure adequate prenatal diets or access to water. Detoxing of pregnant people with opioid use disorder in prison is common.

Figure 10. Caregiving Arrangements at Hospital Discharge Among Infants Born to Mothers at the Minnesota Correctional Facility at Shakopee



Relative to nonpregnant peers, pregnant people in prison are more racially and ethnically diverse, are younger, and have fewer total years of education. Between 2013 and 2020, 278 pregnant people were sentenced to serve time in Minnesota. Thirty-four percent of these women were Native American, 12 percent were Black, and 53 percent were White. More than three-quarters (77 percent) were

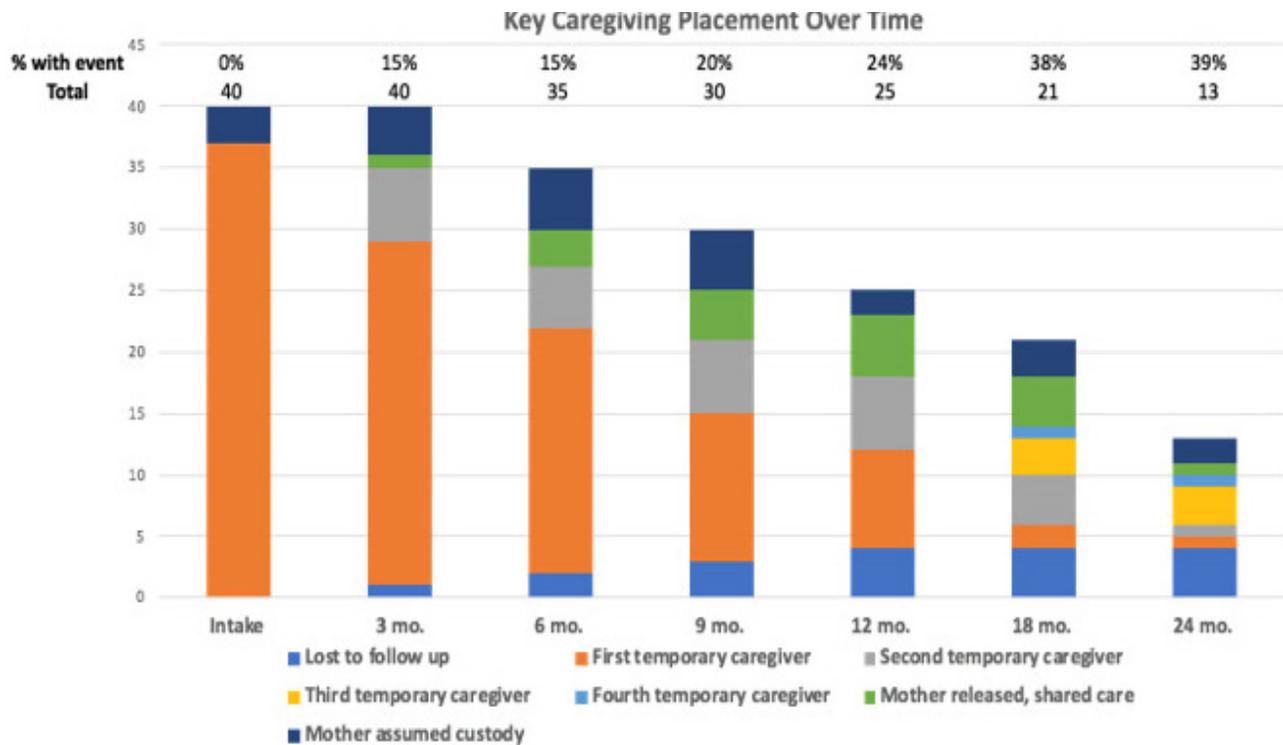
³⁴ Howland, M., Muentner, L., Duwe, G., Clarke, V., & Schlafer, R. (under review). Adverse childhood experiences among parents in prison: Implications for parenting.

³⁵ Proctor, S. L. (2012). Substance use disorder prevalence among female state prison inmates. *The American Journal of Drug and Alcohol Abuse*, 38(4), 278-285. <https://doi.org/10.3109/00952990.2012.668596>

³⁶ Suffrin, C., Beal, L., Clarke, J., Jones, R., & Mosher, W. D. (2019). Pregnancy outcomes in US prisons, 2016-2017. *American Journal of Public Health*, 109(5), 799-805. <https://doi.org/10.2105/AJPH.2019.305006>

³⁷ Suffrin, C., Jones, R. K., Mosher, W. D., & Beal, L. (2020). Pregnancy prevalence and outcomes in U.S. jails. *Obstetrics and Gynecology*, 135(5), 1177-1183. <https://doi.org/10.1097/AOG.00000000000003834>

Figure 11. Key Caregiving Placement Over Time in Birth Behind Bars



in prison for technical violations of supervision, and 84 percent had nonviolent governing offenses. The median length of prison stay was 4.5 months, and 77 percent were sentenced to prison while pregnant for less than 9 months. SUDs were reported by 70 percent. When considering these data in terms of a linear timeline of an infant’s first year of life, 41 percent of mothers who gave birth during their period of incarceration did so within 90 days of their release date. Fifty-four percent reached their release date within 6 months of giving birth, 67 percent were released within 9 months of giving birth, and 76 percent were released within 1 year of giving birth. This indicates that more than three-quarters of these mothers were released and resumed caregiving within 1 year of birth; however they had been separated from their infants within 24 to 48 hours of birth with limited opportunities for nurturing, bonding, and attachment. Further, underlying issues, such as substance misuse, have not been treated, and mothers are being released from prison after a critical developmental time period has passed and are attempting to connect and bond with their infants. The MPDD collected data on caregiving arrangements for infants at hospital discharge among 114 mothers who gave birth at the Minnesota Correctional Facility in Shakopee (Figure 10), and interviewed caregivers regarding the infants’ overall health as well as caregiver physical and

mental health. Frequently, caregivers reported that taking the infant home caused a strain to their physical and mental health. Most placements were informal, without child welfare engagement and with no structural supports in place to assist caregivers. Many caregivers in kinship placements have their own social risk factors for physical and mental health with little financial or other support. A majority of caregivers in this sample indicated that their physical and mental health had declined as a result of becoming caregivers.³⁸ These situations can also lead to CWS involvement when caregivers are no longer healthy enough to take care of the child.

The Birth Behind Bars study is a prospective longitudinal study of children exposed to incarceration in utero. In this study, researchers are interviewing mothers and caregivers in partnership with Motherhood Beyond Bars, a community-based organization in Georgia, every 3 months over the course of 2 years. The current sample size is small, but speaks to the level of transitions in care that are likely to occur for children of mothers who use substances. At intake, some children have already been

³⁸ Pendleton, V. E., Schmitgen, E. M., Davis, L., & Shlafer, R. J. (2021). Caregiving arrangements and caregiver well-being when infants are born to mothers in prison. *Journal of Child and Family Studies*, 1-14. <https://doi.org/10.1007/s10826-021-02089-w>

placed with their first temporary caregiver; these children are represented by the orange bar at the Intake time point in Figure 11. At the 3-month interview, approximately 15 percent of these children are with a second temporary caregiver. By the 6-month time point, another 15 percent of children have moved on to a third temporary caregiver. The number of caregiver transitions experienced by this population is very high, and this makes following children, families, and caregivers of children exposed to incarceration very challenging over time.

Ultimately, the intersections among SUD, maternal incarceration, and child welfare involvement are complex, nonlinear, and unpredictable. Incarcerated mothers, particularly pregnant incarcerated mothers, report high rates of SUD, and SUD can increase risk for involvement in both the carceral and the CWSs. This risk is not evenly distributed; Black and brown mothers, poor mothers, and mothers living in rural areas are more likely to be involved in both of these systems. Dr. Schlafer feels that both systems are inadequate at best, and inhumane at worst, responses to maternal SUD. Finally, caregiving transitions among incarcerated mothers are common, and often unpredictable and informal, making research with this population particularly challenging. Dr. Schlafer believes that families are doing the best that they can in the face of tremendous vulnerability and marginalization. Given the complexity of issues affecting these populations, it is important to consider opportunities for research, intervention, and policy to align.

Session III Questions

Pilar Sanjuan, Ph.D. (*University of New Mexico Health Sciences Center*) asked panelists how much of what they had presented might be related to a mistaken belief of probation officers or other justice system workers, including judges, that incarceration would protect the baby from the mother's substance use or other behaviors.

- Dr. Schlafer noted that she believes this belief is part of the problem; in some states, there are legal mechanisms for incarcerating pregnant people based on an idea of protecting them. In North Carolina, there is a process for “safekeeping,” for incarceration of pregnant people, where preadjudication arrestees are moved to the state prison and separated from the general population rather than kept in jails because the jails have acknowledged that they cannot provide appropriate prenatal care. Much education is needed

to correct false beliefs about what quality of care and treatment actually looks like in correctional facilities. Dr. Schlafer feels that any pregnant and incarcerated individual she has worked with in Minnesota over the past year would indicate that her SUD or mental health needs were not met during incarceration, if asked. In Minnesota, legislation has been passed to allow the Commissioner of Corrections to release pregnant individuals into the community for up to 1 year during their pregnancy; however, one probation officer returned a pregnant individual to prison because he was unable to find her a community-based substance treatment program. This example speaks to the mistaken belief that SUD treatment is provided in prison. One question that should be asked is whether resources should be put into the carceral space in order to improve available care or into upstream spaces in order to prevent sending pregnant people to prison with an assumption that they will receive substance use treatment there.

Dr. Jones-Harden noted that HBCD is encouraging HBCD sites to examine issues around the instability of pregnant individuals with SUD, and she asked what questions HBCD should be asking participants about which services they are actually receiving in the systems they are involved in.

- Dr. Terplan indicated that carcerality is more than incarceration, and there are systems of surveillance and control that extend beyond locking people up. A policing paradigm exists across not only within other agencies, such as the CWS, but also within medicine itself. When discussing decarceration, or release from prison, it is important to also consider ways to decriminalize the health care setting. To determine which questions should be asked, HBCD needs to talk to affected individuals and partner with community-based organizations that know which resources are both available and welcoming to pregnant and parenting people who use substances. In the past 5 years, the NIH has become increasingly aware of the key role of community-based organizations and has begun efforts to fund partnerships that support these organizations. POSC are part of an empowerment model, which gives the individual a resource binder and recovery journey to help shift ownership of the POSC to the individual and away from the state or judge.

- Dr. Jones-Harden noted that it would be important to ask individuals whether they have a POSC.
 - » Mr. Couch indicated that this question would be an excellent addition to the HBCD study if not already included. He asked whether HBCD is capturing the voice of individuals with lived expertise as a part of the study, and whether HBCD includes those at the community level who provide family-centered therapy or treatment who can also speak to which questions should be asked to determine actual level of services and supports received. Many providers had to make a radical shift to view the POSC as belonging to the pregnant individual and family. This approach was seen as scary, and counterintuitive by many providers, and it took considerable work to move providers to asking what individuals want for their POSC. Translating the theology behind this approach to clinical practice was a big deal, but the empowerment of the individuals is resulting in tremendous growth.

Dr. Freund asked how education and information should be disseminated. Social workers are dedicated and want to help, but many may not be aware of the reality of these system, or the empowering approaches that work. How can these things be communicated to those individuals?

- Mr. Couch indicated that when he is working with sites, he asks where the target audience’s attention is focused at the current moment and how information can be brought to that area of focus. In Wyoming, the NCSACW has determined that medical providers are comfortable with webinars and drawn to participate when free continuing medical education credits are provided, and he is using this approach to get information and education in front of providers. Champions who believe in the purpose of the work are also key to promoting and disseminating education and data.
- Dr. Shlafer added that, as a researcher and provider, she feels it is important to “leave the academy.” She began connecting with judges and guardians at litem to share her developmental science expertise by partnering with

an attorney with the legal expertise to help translate information in a useful way. Researchers and providers need to be very intentional in giving the science away to prevent it from becoming extractive.

- Mr. Couch added that a key aspect to this process is taking the research and science and packaging them in a way that is digestible and adds value to the work done by providers in the field.

Dr. Gurka indicated that she was particularly struck by the panelists’ emphasis on considering the experience of women with SUD when attempting to engage them in research. In the context of the care that women who are in treatment for SUD receive during the birthing experience, as well as their trust of the system, patients overwhelmingly indicate that the person who approaches them about being in a research study should not be their doctor or any health care provider, because they do not trust them and believe that they will contact child welfare. The system creates a perverse incentive to avoid prenatal care and substance use treatment, because patients will be labeled as substance users and will receive poorer care when hospitalized as a result. Have any assessments looked at actual changes in practice, rather than changes in policy, and making individuals who are pregnant and use substances aware of these changes? It is their perception that determines their engagement in care and research, not the reality of the policy or practice.

- Mr. Couch re-emphasized the importance of engaging individuals with lived expertise in research, information dissemination, and actual implementation of changes to practice. In the STAR clinic in Oklahoma City, NCSACW helped to train nurses and all staff to understand that the patients’ experience begins the moment they are first in contact with the clinic. Patients need to feel valued and validated from the first contact. This model was carefully designed and implemented, but there was still a need to dispel the stigma and perceptions in and of these systems of care. To do this, NCSACW engaged people with lived expertise to participate in outreach efforts and to partner as peer supports with new clinic patients within 2 weeks of their arrival at the clinic. These are practical examples of ways to create meaningful change.

An audience participant indicated that in looking at the laws related to prenatal substance exposure and reporting or notification, her team found that even in states that have developed CAPTA notification pathways, residual laws from the 1990s and early 2000s, which were established in response to cocaine use and perceived “crack babies” or methamphetamine use, still exist that trigger an automatic report when a child tests positive at birth or a mother tests positive for use during the pregnancy. Even in cases where an automatic CWS report is not triggered, the positive test creates a presumption that a woman is an unfit mother in a termination of parental rights setting. Connecticut is an example of a state with a very convoluted legal pathway for practitioners to navigate, where a positive test result still requires a report of child abuse. This policy has not changed. How can policy be established that is actually coherent? Also, how does the carceral gaze in medical practice influence the provider-patient relationship?

- Mr. Couch stated that the best way to establish useful, coherent policy and make sure that it is disseminated is to get the right experts in front of policymakers in a receptive space. Knowing whom the experts are and bringing people together, creating a receptive atmosphere, and creating space for follow-up discussion take work, but these relationship-based interactions are the approaches that work. The best policies evolve from someone saying “Hey, we could do this better.”

- Dr. Terplan noted that the provider-patient relationship is affected by stigma, discrimination, and many things that have not yet been discussed in detail. Laws and forgotten legislation can hang around and suddenly become salient again; most do not naturally sunset. Specific state policies are not necessary to arrest, prosecute, and incarcerate pregnant people for substance use; this can still happen when there are laws that protect autonomy in pregnancy and parenting that do not prohibit arrest, prosecution, and incarceration. In the 2 weeks preceding the workshop, Dr. Terplan was involved in 10 criminal cases related to pregnancy and substance use. Issues often relate to information flow. In many cases where women have been incarcerated for using substances during pregnancy, there is information in the court record that directly quotes the medical record. Care is not safe, and birth is increasingly unsafe for pregnant people who use drugs. One pathway to addressing these problems is to consider discrimination as a patient safety issue. This can be connected work by the Perinatal Quality Collaborative and processes at the state level that have looked at hemorrhage, Cesarean section rates, and other sorts of outcomes. Much work still needs to be done to better measure things like stigma and discrimination in this area, and viewing discrimination as a patient safety issue and birth as unsafe in the United States is one place to start.

Session IV: The Science on Children/Families in Child Welfare I

*(Julie Poehlmann, Ph.D., University of Wisconsin; Amanda Tarullo, Ph.D., Boston University;
Jody Todd Manly, Ph.D., University of Rochester)*

Dr. Poehlmann noted that one of the workshop goals was to summarize the scientific evidence on the sequelae of child maltreatment and foster care on the brain and behavioral development of affected children and on the functioning and processes of families involved with the CWS, and the impact of child welfare services on involved children and families. Session IV is the first half of two scientific sessions intended to address this goal and is focused on the science regarding the effects of maltreatment. Dr. Poehlmann introduced Dr. Manly, Clinical Director at the Mount Hope Family Center (MHFC) at the University of Rochester and a leader in the field of developmental psychopathology. Dr. Manly brings 35 years of experience in providing clinical services to children who have experienced trauma, with a focus on the infancy-to-adolescence period.

Effects of Child Maltreatment: Developmental Pathways for Children and Adolescents (Jody Todd Manly)

Dr. Manly indicated that the MHFC is part of the National Child Traumatic Stress Network, and, as part of the Network, the MHFC provides evidence-based trauma treatment services to children and families. Through SAMHSA funding, the MHFC also leads a project called “Sustaining Change,” which supports organizations for implementing evidence-based trauma treatment and sustaining them over time. As a researcher, Dr. Manly also represents the Translational Research that Adapts New Science FOR Maltreatment (TRANSFORM) Research Center, a CAPSTONE center on child abuse and neglect supported by the *Eunice Kennedy Shriver* National Institute of Child Health and Human Development. Under the leadership of principal investigators Dante Cicchetti, Ph.D., and Sheree Toth, Ph.D., the Center is conducting both basic and applied research and working to put that research into the hands of transdisciplinary professionals and translational researchers to adapt new science for maltreatment prevention. TRANSFORM has an extensive data archive including more than two decades of research into child abuse and neglect, and examples from these data are included in this Effects of Child Maltreatment: Developmental Pathways for Children and Adolescents presentation.

Through a developmental psychopathology lens, TRANSFORM is trying to understand normative child development, as well as atypical child development, and how different trajectories can inform ways to support children and families. This involves looking at the balance between risk and protective factors. There is no clear, single pathway that an abused or neglected child follows. Instead, there is a great deal of heterogeneity in the experiences children have, and it is important to view children in the context of their families, communities, and broader cultural aspects of development. TRANSFORM researchers are particularly interested in developmental timing and in how child maltreatment that occurs during a certain period of development can affect the mastery of stage-salient developmental tasks of that period.

Developmental psychopathology includes the principle of equifinality, which describes a process through which many different pathways can result in a single outcome such as SUD, as well as the principle of multifinality, in which a single aspect of the history or developmental pathway of an individual does not define his or her trajectory. An individual may have resilient and adaptive outcomes despite a history of trauma as well as challenges. Research at MHFC and in the field has demonstrated that child maltreatment can affect multiple domains of development. In the 25 years since the ACEs study was published, evidence has emerged of long-term physiological consequences of ACEs, including disruptions in neuroendocrine stress hormone regulation that affect immune functioning. Different genotypic profiles may convey risk or resilience, and research on epigenetics is beginning to identify ways that different environmental experiences can affect gene expression. If adversity experienced in childhood is chronic, it can increase allostatic load for affected individuals. Interpersonal development is also affected by child maltreatment; children who have experienced maltreatment are more likely to have insecure and disorganized attachment relationships. Early disruptions to the attachment process, such as those that can occur in the CWS and foster care, and development of trust and understanding of relationships in the early years of life can be associated with later difficulties in relationships with peers, teachers, and other individuals in their lives.

Children who have experienced maltreatment and neglect in early life are more likely to exhibit increased aggression toward and withdrawal from peers, greater peer rejection and victimization, and greater difficulty developing and maintaining friendships. Child maltreatment can also affect the emotional domain, adaptation to school, and personality and psychopathology. Children who have been maltreated may have more difficulty recognizing, expressing, and regulating emotions and are at greater risk for lower academic achievement or academic failure, behavioral problems, mood and personality disorders, SUD, and antisocial or suicidal behavior. Developmental cascades may occur, where problems in one domain can ripple across others, as in cases where children who have difficulty with relationships with peers and emotion regulation may have difficulties adapting to school.³⁹

Significant differences in legal definitions of child maltreatment across states and counties, and between U.S. policies and policies in other countries, can make research on the topic difficult. In collaboration with Dr. Cicchetti and Douglas Barnett, Ph.D. Dr. Manly developed a maltreatment classification system to facilitate empirical research on the impact of maltreatment on children's adaptation over time.⁴⁰ Much attention has been paid to the subtype of abuse, (e.g., physical abuse, sexual abuse, neglect, and emotional or psychological maltreatment), but Drs. Cicchetti, Barnett, and Manly felt it was also important to focus on other aspects, such as the seriousness of the parental behaviors, the timing of experiences, ways that experiences interacted with children's developmental periods, and identity of the perpetrator as well as the relationship with the perpetrator. Specific to child welfare, the system also looks at the ways that experiences of abuse affect the impact of separations and placements in care. The system addresses multiple dimensions of maltreatment, including:

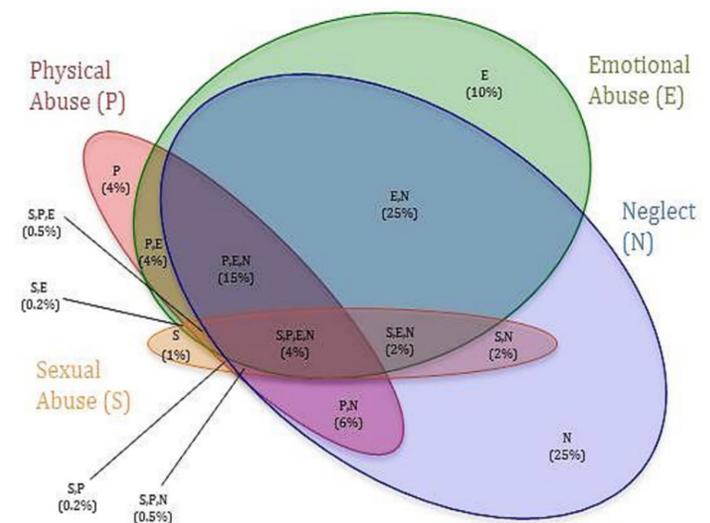
1. subtype
2. severity
3. frequency/chronicity of experiences and the ways they interact
4. developmental period
5. separations/placements

³⁹ Cicchetti, D., & Toth, S. L., (2016). Child maltreatment and developmental psychopathology: A multilevel perspective. In D. Cicchetti (Ed.), *Developmental psychopathology: Vol. 3. Maladaptation and psychopathology* (3rd ed., pp. 457-512). Wiley.

⁴⁰ Barnett, D., Manly, J. T., & Cicchetti, D. (1993). Defining child maltreatment: The interface between policy and research. In D. Cicchetti & S. L. Toth (Eds.), *Child abuse, child development, and social policy* (pp. 7-74). Ablex.

and the ways that these dimensions shape children's outcomes. Subtypes often overlap, and experiences often co-occur and can persist across development. In a sample of 2,292 children aged 5 to 13 years, Vachon and colleagues⁴¹ found tremendous overlap between subtypes of abuse (Figure 12). Experiences of different subtypes often co-occur and can persist across development. Most sexually abused children in this sample have experienced multiple forms of maltreatment. Neglect occurs independently of other types to a greater extent than any other category, but neglect in the form of absence of supervision can also place children at risk of subsequent trauma.

Figure 12. Overlapping Subtypes of Abuse



Individuals who experience childhood maltreatment are at increased risk of substance use problems. Maltreatment places individuals at greater risk of earlier initiation of drinking, faster increases in heavy drinking during adolescence, and persistent elevated heavy drinking during adolescence and adulthood.⁴² Adolescent girls with a history of childhood sexual abuse are about 5 times more likely to be heavy polysubstance users compared to those without sexual abuse histories.⁴³ None of these risk factors are deterministic; all outcomes depend upon a probabilistic balancing of risk and resilience. If research can help

⁴¹ Vachon, D. D., Krueger, R. F., Rogosch, F. A., & Cicchetti, D. (2015). Assessment of the harmful psychiatric and behavioral effects of different forms of child maltreatment. *JAMA Psychiatry*, 72(11), 1135-1142. <https://doi.org/10.1001/jamapsychiatry.2015.1792>

⁴² Cicchetti, D., & Handley, E. D. (2019). Child maltreatment and the development of substance use and disorder. *Neurobiology of Stress*, 10, Article 100144. <https://doi.org/10.1016/j.ynstr.2018.100144>

⁴³ Shin, S. H., Hong, H. G., & Hazen, A. L. (2010). Childhood sexual abuse and adolescent substance use: A latent class analysis. *Drug and Alcohol Dependence*, 109(1-3), 226-235. <https://doi.org/10.1016/j.drugalcdep.2010.01.013>

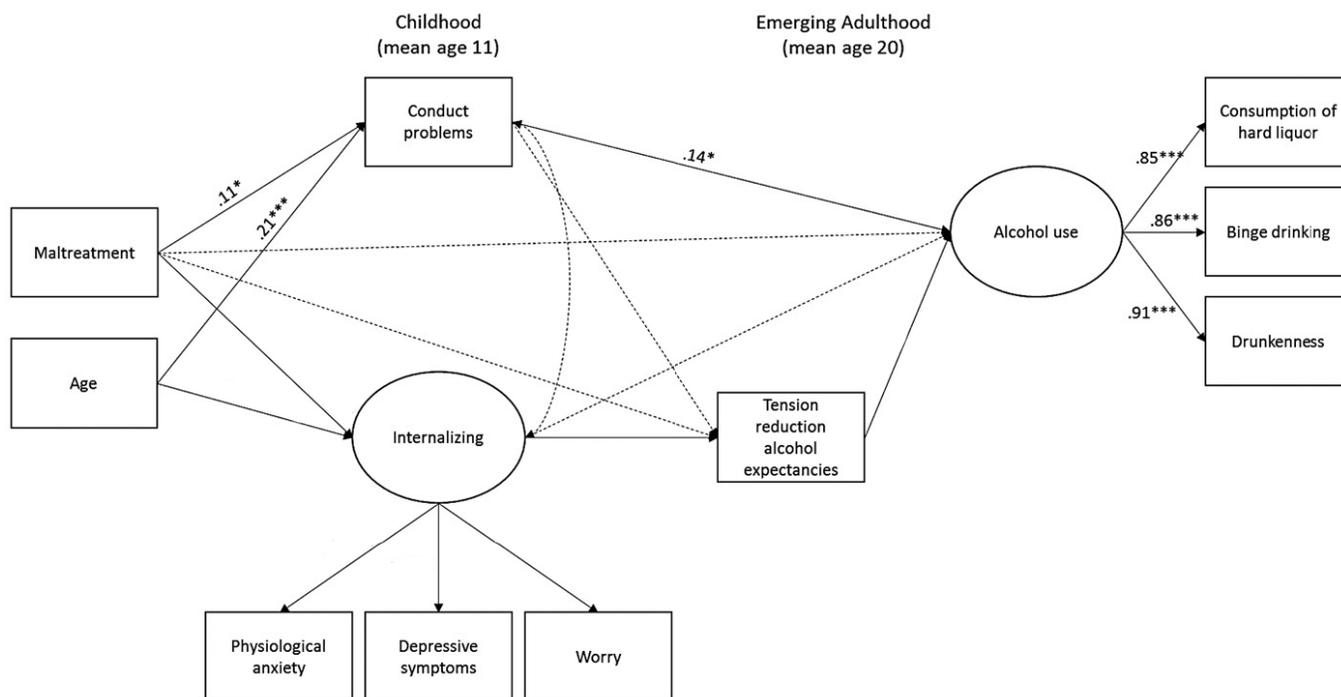
to identify the processes and mechanisms by which maltreatment increases risk of negative outcomes, it may also be possible to identify points in these processes for preventative efforts and interventions and to develop more effective responses.

One potential pathway from childhood maltreatment to substance use and other problematic outcomes is the externalizing pathway, also called the Undercontrol/Disinhibition/Deviance Proneness Pathway. Evidence supports this pathway in terms of both substance use in general and maltreatment specifically. On this pathway, difficult temperament in infancy can lead to increases in aggression and poor self-regulation in early childhood, which may lead to increases in rule-breaking behavior in middle childhood and affiliations with substance-using peers in adolescence. MHFC research has demonstrated that children who experience maltreatment are more likely to engage in rule-breaking behavior, experience

problems with impulsivity and self-regulation, and exhibit aggression,⁴⁴ providing support for the application of this model to the relationship between childhood maltreatment and later substance misuse. Using a 20-year longitudinal design, MHFC researchers studying risk for alcohol misuse found that conduct problems between the ages of 10 and 12 were associated with increased alcohol use at age 20 in children with a history of maltreatment (Figure 13).⁴⁵

Further work with the same sample of children examined the relationship between maltreatment and antisocial behavior and relational aggression in childhood, and found that experience of a greater number of maltreatment subtypes was significantly associated with higher levels of childhood antisocial behavior and relational aggression in childhood, which subsequently predicted more interpersonal problems in romantic relationships and friendships in early adulthood.⁴⁶

Figure 13. Pathways from Maltreatment to Alcohol Use

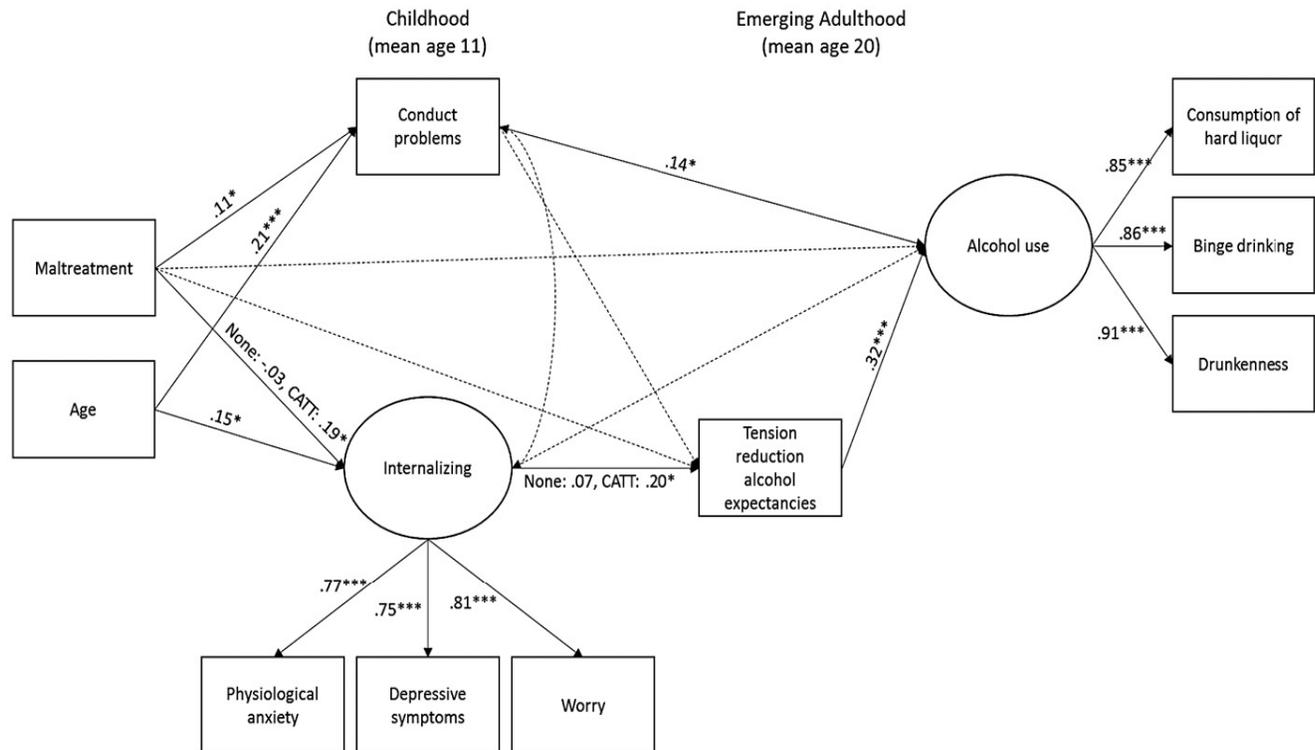


⁴⁴ Cicchetti, D., & Toth, S. L. (2015). Child maltreatment. In M. Lamb (Ed.), *Handbook of child psychology and developmental science: Vol. 3. Socioemotional process* (7th ed., pp. 513-563). Wiley. <https://www.wiley.com>

⁴⁵ Source: Handley, E. D., Rogosch, F. A., & Cicchetti, D. (2017). From child maltreatment to emerging adult problem drinking: Identification of a multilevel internalizing pathway among African-American youth. *Developmental Psychopathology*, 29(5), 1807-1822. <https://doi.org/10.1017/S0954579417001419>

⁴⁶ Handley, E. D., Russotti, J., Rogosch, F. A., & Cicchetti, D. (2019). Developmental cascades from child maltreatment to negative friend and romantic interactions in emerging adulthood. *Development and Psychopathology*, 31(5), 1649-1659. <https://doi.org/10.1017/S095457941900124X>

Figure 14. Genetic Moderation in the Internalizing Pathway from Childhood Maltreatment to Alcohol Use



Timing and chronicity of maltreatment also appear to play a role in developmental trajectories. Russotti et al.⁴⁷ incorporated information on timing and chronicity into the classification of maltreatment in a predictive model, and found that maltreatment that emerged early in childhood and was more chronic was associated with both internalizing and externalizing behaviors in childhood; however, emergence of antisocial personality disorder and SUDs were associated with only the externalizing pathway.

SUD in adulthood can also be connected to childhood maltreatment through a slightly more complicated and nuanced internalizing/negative affect pathway.⁴⁸ In this model, babies who have a more inhibited temperament in childhood may develop more internalizing symptoms, such as anxiety and depression, in early childhood. If these symptoms continue into middle and late childhood, these children may experience more problems with interpersonal skills. In these children, positive expectancies about substance use can develop into self-medication to cope with

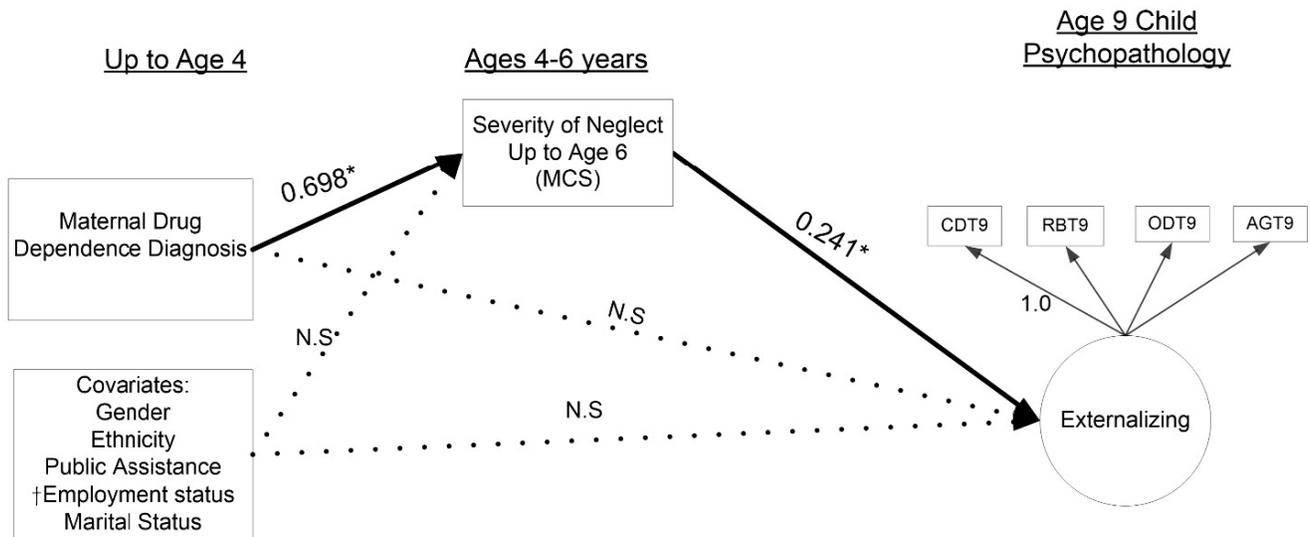
negative emotions and mood difficulties. This model aligns with evidence that maltreated children are more likely to experience symptoms of depression and anxiety, as well as social withdrawal and peer problems, and as these children develop, some use substances as a means of coping with these negative feelings.^{42, 49} Genetic variation (FKBP5 CATT haplotype) increases the likelihood that individuals who have experienced maltreatment will drink to cope with negative emotions (Figure 14).^{45, 50}

There are also intergenerational factors to consider in both externalizing and internalizing models. Parental substance use can increase the risk of maltreatment for children. In a study examining the influence of early maternal drug dependence, Manly and colleagues⁵⁰ found that maternal drug dependence diagnoses prior to the age of 4 increased the risk of maltreatment, specifically the severity of neglect, in preschool and early school years. This neglect was then associated with externalizing and internalizing behavior around age 9 (Figure 15).

⁴⁷ Russotti, J., Warmingham, J. M., Duprey, E. B., Handley, E. D., Manly, J. T., Rogosch, F. A., & Cicchetti, D. (2021). Child maltreatment and the development of psychopathology: The role of developmental timing and chronicity. *Child Abuse & Neglect*, 120, Article 105215. <https://doi.org/10.1016/j.chiabu.2021.105215>
⁴⁸ Hussong, A. M., Jones, D. J., Stein, G. L., Baucom, D. H., & Boeding, S. (2011). An internalizing pathway to alcohol use and disorder. *Psychology of Addictive Behaviors*, 25(3), 390-404. <https://doi.org/10.1037/a0024519>

⁴⁹ Mezquita, L., Ibáñez, M. I., Moya, J., Villa, H., & Ortet, G. (2014). A longitudinal examination of different etiological pathways to alcohol use and misuse. *Alcoholism: Clinical and Experimental Research*, 38(6), 1770-1779. <https://doi.org/10.1111/acer.12419>
⁵⁰ Manly, J. T., Oshri, A., Lynch, M., Herzog, M., & Wortel, S. (2013). Child neglect and the development of externalizing behavior problems: Associations with maternal drug dependence and neighborhood crime. *Child Maltreatment*, 18(1) 17-29. <https://doi.org/10.1177/1077559512464119>

Figure 15. Parental Substance Use, Neglect, and Childhood Externalizing Behaviors



Many adults with SUD report parental experiences with the same SUD; however, the processes that drive a pattern of intergenerational substance misuse require further investigation. Specifically, research is needed to examine parental histories of trauma and the ways that they affect parenting beyond particular parenting practices. Children who experience maltreatment are affected in multiple domains through childhood and adolescence and may grow up to become parents themselves. How do different aspects of maltreatment, as in the classification system, and their influence on developmental domains, affect later ability to regulate emotion when parenting? How do they affect their interpersonal relationships with partners and friends and contribute to a lack of social support? How do these things impact the parent’s relationship with a child? By examining questions like these, researchers can begin to better understand how to address parental trauma and better support families. In work studying intergenerational patterns, Blake and colleagues⁵¹ found associations between parental substance use and substance use in the subsequent generation, but also that a history of family separations was a key contributor to increased risk for substance use in the later generation. This is particularly relevant when discussing child welfare contexts. Although there are certainly times that children must be removed from the home to ensure their safety, it is important to be very mindful of the implications of those separations and changes in caregiving in terms of the impact on children’s development.

⁵¹ Blake, A. J., Mackinnon, D. P., Waddell, J., & Chassin, L. (2023). Parent-child separation and intergenerational transmission of substance use and disorder: Testing across three generations. *Development and Psychopathology*. Advance online publication. <https://doi.org/10.1017/S0954579422000876>

There are also examples of evidence-based prevention and intervention models that can be effective. Some of these may not be included in the Title IV-E Preventative Services Clearinghouse, because the clearinghouse includes only treatment evaluation studies that compare treatment to a no-treatment or waitlist comparison group. Two examples of evidence-based prevention and intervention models are Child-Parent Psychotherapy and Perinatal Child-Parent Psychotherapy (P-CPP). Child-Parent Psychotherapy is a part of the Zero to Three Safe Baby Court Teams models, and the newer P-CPP approach is being used to address parental histories of trauma and support pregnant people before the baby is born to hopefully establish a positive trajectory.

In thinking about building resilience for children, it is important to consider ways that this can be accomplished by supporting their relationships, building positive role models for them, identifying their strengths and talents, helping them to feel in control and welcomed and belonging, even when in foster care or other placements. Key points that HBCD researchers may want to consider include the following:

- Maltreatment is a heterogeneous phenomenon with multiple dimensions.
- Children who have experienced maltreatment are at risk for developing substance use problems.
- Risk for substance use is related to many interconnected factors, including impulsivity, emotion regulation challenges, time spent with substance-using friends, and use of alcohol and drugs to cope with difficult feelings.

- There are a number of evidence-based prevention and intervention programs that can reduce risk for children by helping with many of these factors.

The Impact of Maltreatment, Foster Care, and Poverty on the Developing Brain (Amanda Tarullo)

Dr. Poehlmann introduced Dr. Tarullo, an Associate Professor of psychological and brain sciences at Boston University. Dr. Tarullo's research examines resilience in children who have experienced trauma.

While there is no intrinsic value in creating maps of neural correlates or hormonal effects of child maltreatment and poverty on the developing brain, doing so may help explain pathways from early abuse and neglect to later mental health, socioemotional, and cognitive outcomes. Understanding how impacts of early abuse and neglect on the brain lead to outcomes may inform intervention approaches and inform policy. Although it is obvious to researchers that many mental health and other outcomes have origins in the brain, policymakers sometimes find scientific evidence of brain-damaging effects to be more compelling than evidence of mental health or other symptoms.

The Impact of Child Maltreatment on Brain Structure and Function

Child maltreatment is associated with:

- overall reduced brain volume
- alterations to amygdala volume
- reduced anterior cingulate volume
- reduced cerebellum volume
- reduced volume of corpus callosum and other fiber tracts
- reduced hippocampal volume (at least by adulthood)^{52,53,54,55}

These effects can be interpreted as indications of damage or as adaptive responses to maltreatment. It is possible that some changes are adaptations to help children function within a specific environment of abuse or neglect that may

prove problematic in other contexts. All changes listed are in brain areas known to be involved in threat detection. Most of the impacted regions have dense glucocorticoid receptors that respond to biological stress, and it is possible that maltreatment is causing stress hormone cascades that are then affecting the development of regions of the brain that are sensitive to biological stress. Animal research suggests that the relationship between maltreatment and brain abnormalities is causal. In addition to affecting the structure of regions that respond to threat, maltreatment is associated with reduced connectivity between these regions. All brain effects are very nuanced and depend upon the timing of exposure to maltreatment, the current age of the child, the type of maltreatment, and the presence of psychopathology and/or substance misuse.⁵⁶

Structural abnormalities predict and relate to behavioral and mental health problems, and thus serve as indicators that a child may experience more mental health challenges than a child without abnormalities. One example commonly seen in children who have experienced maltreatment is increased amygdala volume, a structural change that has been linked to increased anxiety.⁵⁷

In addition to structural changes, child maltreatment is associated with brain functioning, specifically how brain regions respond in real-world situations. Research has consistently demonstrated that emotional stimuli, especially fear and anger, are more salient for children who have experienced maltreatment. This is seen in increased amygdala reactivity to emotional faces,⁵⁷ stronger brain electrical responses to angry faces,⁵⁸ and hyperactivation of ventromedial prefrontal cortex and anterior cingulate to fearful faces in maltreated adolescents.⁵⁹ In the context of maltreatment, this heightened salience of fear and anger can be adaptive; however, hypervigilance and hypersensitivity to others' emotions persist in other contexts and can cause fear, anxiety, and social difficulties. Maltreatment has also been

⁵² Baker, L. M., Williams, L. M., Korgaonkar, M. S., Cohen, R. A., Heaps, J. M., & Paul, R. H. (2013). Impact of early vs. late childhood early life stress on brain morphometrics. *Brain Imaging and Behavior*, 7(2), 196-203. <https://doi.org/10.1007/s11682-012-9215-y>

⁵³ De Bellis, M. D., Keshavan, M. S., Shifflett, H., Iyengar, S., Beers, S. R., Hall, J., & Moritz, G. (2002). Brain structures in pediatric maltreatment-related posttraumatic stress disorder: A sociodemographically matched study. *Biological Psychiatry*, 52(11), 1066-1078. [https://doi.org/10.1016/S0006-3223\(02\)01459-2](https://doi.org/10.1016/S0006-3223(02)01459-2)

⁵⁴ Kumari, V., Gudjonsson, G. H., Raghuvanshi, S., Barkataki, I., Taylor, P., Sumich, A., Das, K., Kuipers, E., Ffytche, D. H., & Das, M. (2013). Reduced thalamic volume in men with antisocial personality disorder or schizophrenia and a history of serious violence and childhood abuse. *European Psychiatry*, 28(4), 225-234. <https://doi.org/10.1016/j.eurpsy.2012.03.002>

⁵⁵ Van Dam, N. T., Rando, K., Potenza, M. N., Tuit, K., & Sinha, R. (2014). Childhood maltreatment, altered limbic neurobiology, and substance use relapse severity via trauma-specific reductions in limbic gray matter volume. *JAMA Psychiatry*, 71(8), 917-925. <https://doi.org/10.1001/jamapsychiatry.2014.680>

⁵⁶ Teicher, M. H., & Samson, J. A. (2016). Annual research review: Enduring neurobiological effects of childhood abuse and neglect. *Journal of Child Psychology and Psychiatry*, 57(3), 241-266. <https://doi.org/10.1111/jcpp.12507>

⁵⁷ McLaughlin, K. A., Peeverill, M., Gold, A. L., Alves, S., & Sheridan, M. A. (2015). Child maltreatment and neural systems underlying emotion regulation. *Journal of the American Academy of Child & Adolescent Psychiatry*, 54(9), 753-762. <https://doi.org/10.1016/j.jaac.2015.06.010>. Erratum in: *Journal of the American Academy of Child & Adolescent Psychiatry*. (2017). 56(2), 181. <https://doi.org/10.1016/j.jaac.2016.12.004>

⁵⁸ Shackman, J. E., Shackman, A. J., & Pollak, S. D. (2007). Physical abuse amplifies attention to threat and increases anxiety in children. *Emotion*, 7(4), 838-852. <https://doi.org/10.1037/1528-3542.7.4.838>

⁵⁹ Hart, H., Lim, L., Mehta, M. A., Simmons, A., Mirza, K. A. H., & Rubia, K. (2018). Altered fear processing in adolescents with a history of severe childhood maltreatment: An fMRI study. *Psychological Medicine*, 48(7), 1092-1101. <https://doi.org/10.1017/S0033291716003585>

associated with a reduced neural response to anticipated award,^{60, 61} suggesting that the brains of maltreated children are more focused on negative stimuli.

The Impact of Maltreatment: Stress Physiology

Cortisol systems are immature when children are born and are very much shaped by early experience. Cortisol plays a key role in physical and mental health in adulthood, and the way that the system develops in the early years of life has long-term consequences for both. In a recent meta-analysis looking at child maltreatment and cortisol, Schar and colleagues⁶² found that children with a history of maltreatment exhibited blunted cortisol reactivity to stress. This is likely due to suppression of the cortisol system in response to chronic activation, resulting in a reduced ability to respond to challenges effectively. Other findings were less consistent across studies, possibly because of differences in experiences of maltreatment combined with the differential impact of varying types of psychopathology on cortisol system functioning. Using hair cortisol concentrations as an indicator of chronic biological stress, White and colleagues⁶³ found that child maltreatment was linked to decreases in hair cortisol concentrations in middle childhood and adolescence, further supporting downregulation of the biological stress response system in maltreated children. Emerging research also suggests that epigenetic changes occur in genes involved in biological stress, specifically those involved in the regulation of the hypothalamic-pituitary-adrenal axis.^{64, 65}

⁶⁰ Boecker, R., Holz, N. E., Buchmann, A. F., Blomeyer, D., Plichta, M. M., Wolf, I., Baumeister, S., Meyer-Lindenberg, A., Banaschewski, T., Brandeis, D., & Laucht, M. (2014). Impact of early life adversity on reward processing in young adults: EEG-fMRI results from a prospective study over 25 years. *PLOS ONE*, 29(8), e104185. <https://doi.org/10.1371/journal.pone.0104185>. Erratum in: *PLOS ONE*. (2014). 9(10), e112155.

⁶¹ Mehta, M. A., Gore-Langton, E., Golembo, N., Colvert, E., Williams, S.C., & Sonuga-Barke, E. (2010). Hyporesponsive reward anticipation in the basal ganglia following severe institutional deprivation early in life. *Journal of Cognitive Neuroscience*, 22(10), 2316-2325. <https://doi.org/10.1162/jocn.2009.21394>

⁶² Schär, S., Mürner-Lavanchy, I., Schmidt, S. J., Koenig, J., & Kaess, M. (2022). Child maltreatment and hypothalamic-pituitary-adrenal axis functioning: A systematic review and meta-analysis. *Frontiers in Neuroendocrinology*, 66, Article 100987. <https://doi.org/10.1016/j.yfrne.2022.100987>

⁶³ White, L. O., Ising, M., von Klitzing, K., Sierau, S., Michel, A., Klein, A. M., Andreas, A., Keil, J., Quintero, L., Müller-Myhok, B., Uhr, M., Gausche, R., Manly, J. T., Crowley, M. J., Kirschbaum, C., & Stalder, T. (2017). Reduced hair cortisol after maltreatment mediates externalizing symptoms in middle childhood and adolescence. *Journal of Child Psychology and Psychiatry*, 58(9), 998-1007. <https://doi.org/10.1111/jcpp.12700>

⁶⁴ Heim, C. M., Entringer, S., & Buss, C. (2019). Translating basic research knowledge on the biological embedding of early-life stress into novel approaches for the developmental programming of lifelong health. *Psychoneuroendocrinology*, 105, 123-137. <https://doi.org/10.1016/j.psyneuen.2018.12.011>

⁶⁵ Turecki, G., & Meaney, M. J. (2016). Effects of the social environment and stress on glucocorticoid receptor gene methylation: A systematic review. *Biological Psychiatry*, 79(2), 87-96. <https://doi.org/10.1016/j.biopsych.2014.11.022>

The Broader Context: Impact of Poverty

Children experiencing maltreatment are also more likely to be experiencing poverty, prenatal substance use, and other challenges, and it is important to look across fields at the interactions between the impacts of things like poverty and maltreatment on the brain. Low socioeconomic status (SES) is associated with early-emerging deficits in executive function, including deficits in impulse inhibition and attention regulation. These deficits, in turn, predict poorer academic achievement,^{66, 67} and can impact social interactions. Low SES is also associated with structural differences in neural regions involved with executive function.⁶⁸ Less is known about the impact on the way the brain actually functions and processes demands during attention and inhibitory control tasks. In a go/no-go task using zoo animals, St. John and colleagues⁶⁹ examined brain response in 4- and 5-year-olds during attention allocation and inhibitory control. Children from low-income backgrounds had blunted parietal neural response (P3b ERP component) to stimuli that required inhibition of action. Results indicated initial neural response (prior to 400 milliseconds following stimuli) was similar between low- and high-income children, but then diverged, suggesting that perceptual processing of the stimuli was similar, but higher-level cognitive processing was less robust in children from low-income backgrounds. Patterns like this could mean that to children who have to manage their emotions and behavior in challenging environments, the stimulus is less salient. This may have implications for interventions, if these differences are indicative that the brain is less responsive to inhibitory stimuli.

Lopera-Perez and colleagues looked at the impact of poverty on brain function during social interactions using electroencephalogram (EEG) coherence to evaluate similarities and differences in frontal lobe activation relative to the rest of the brain in nonsocial and social conditions. EEG was recorded from infants (12 months old) when viewing objects on a screen (nonsocial) and when a friendly researcher entered the room and began pointing at objects and talking to the infant (social

⁶⁶ Fuhs, M. W., Nesbitt, K. T., Farran, D. C., & Dong, N. (2014). Longitudinal associations between executive functioning and academic skills across content areas. *Developmental Psychology*, 50(6), 1698-1709. <https://doi.org/10.1037/a0036633>

⁶⁷ Raver, C. C., Blair, C., & Willoughby, M. (2013). Poverty as a predictor of 4-year-olds' executive function: New perspectives on models of differential susceptibility. *Developmental Psychology*, 49(2), 292-304. <https://doi.org/10.1037/a0028343>

⁶⁸ Noble, K. G., Engelhardt, L. E., Brito, N. H., Mack, L. J., Nail, E. J., Angal, J., Barr, R., Fifer, W. P., Elliott, A. J., & PASS Network. (2015). Socioeconomic disparities in neurocognitive development in the first two years of life. *Developmental Psychobiology*, 57(5), 535-551. <https://doi.org/10.1002/dev.21303>

⁶⁹ St. John, A. M., Finch, K., & Tarullo, A. R. (2019). Socioeconomic status and neural processing of a go/no-go task in preschoolers: An assessment of the P3b. *Developmental Cognitive Neuroscience*, 38, Article 100677. <https://doi.org/10.1016/j.dcn.2019.100677>

interaction). Higher-income infants exhibited lower EEG coherence, indicating more specialization of brain activity during social interactions than nonsocial interactions, but lower-income infants exhibited similar EEG coherence in both conditions, suggesting that the brains of higher-income infants were adapting to context, but the brains of lower-income infants were less engaged by social interactions and did not adapt to differences in context. Adaptation to context is essential to taking full advantage of learning experiences and positive social interactions.

Cortisol dysfunction may be one way in which early childhood poverty is connected to adverse adult physical and mental health outcomes and, therefore, offers one potential pathway through which socioeconomic health disparities occur. However, poverty and cortisol are both multidimensional: income-to-needs ratio, parental education, parental occupation and prestige, food insecurity, household chaos, and neighborhood chaos are all aspects of poverty; both daily regulation and cumulative exposure are important dimensions of cortisol function. In a study looking at different dimensions of poverty and cortisol, Dr. Tarullo and her colleagues found that factors of poverty involving unpredictability, including food insecurity, perceived level of neighborhood chaos, and household chaos, were most strongly associated with children's salivary (daily) and hair (cumulative) cortisol levels. Food insecurity and parental perception of neighborhood level of danger accounted for 18 percent of variance in cumulative cortisol exposure [$F(2,67) = 8.62, p < .001$ in infants; in 3- to 5-year-old children, food insecurity and parental education levels accounted for 22 percent of variance in cumulative cortisol exposure [$F(2,80) = 12.80, p < .001$. Findings in infants are especially interesting, given that infants have no innate awareness of neighborhood danger or chaos, and it is likely that the impact on cortisol occurs through parental biological stress. High levels of salivary cortisol at bedtime were linked to household chaos and income-to-needs ratio in both infants and 3- to 5-year-old children ($p < .05$). These findings align with and extend research in adults linking high hair cortisol levels to unpredictable and unsafe contexts.⁷⁰ Given the unpredictability and instability commonly associated with CWS involvement and the foster care system, these findings may be especially relevant when considering the physiological impact of parental and child experiences of unpredictability and instability.

⁷⁰ Henley, P., Lowthers, M., Koren, G., Fedha, P. T., Russell, E., VanUum, S., Arya, S., Darnell, R., Creed, I. F., Trick, C. G., & Bend, J. R. (2014). Cultural and socio-economic conditions as factors contributing to chronic stress in sub-Saharan African communities. *Canadian Journal of Physiology and Pharmacology*, 92(9), 725-732. <https://doi.org/10.1139/cjpp-2014-0035>

Intervention

Very little research has been conducted to examine the impact of intervention on brain structure and function, but given the multiple sensitive periods in early childhood, without intervention it is likely that enduring effects on the brain will occur. Findings from the Bucharest Early Intervention Project provide some evidence that the neural effects of orphanage-based neglect may be mitigated by early placement in enriched foster care environments,⁷¹ but the potential for full reversibility of alterations in brain structure and function is unknown. More evidence of the positive impact of interventions is seen in daily cortisol function improvements in children in the CWS. Transitions in foster care are associated with dysregulations in biological stress; however, intensive interventions appear to lessen dysregulation and may act as protective factors. Attachment and Biobehavioral Catch-Up was associated with better regulated daily cortisol rhythm, persisting 3 years after intervention,⁷² and Child-Parent Psychotherapy and a Psychoeducational Parenting Intervention have been associated with morning cortisol levels similar to those of a community sample.⁷³ Multidimensional Treatment Foster Care for Preschoolers has been associated with stability of daily cortisol rhythms from preplacement to 6 months after placement, relative to children in foster care without this intervention, who exhibit increased dysregulation of daily cortisol following placement.⁷⁴ Interventions appear to be less effective on cortisol response to a stressor.⁷⁵

When considering the impact of maltreatment, foster care, and poverty on the developing brain, HBCD researchers may want to keep the following summary points in mind:

- Child maltreatment is linked to widespread reductions in brain volume, especially in regions involved in emotion regulation and response to threat.

⁷¹ Sheridan, M. A., Fox, N. A., Zeanah, C. H., McLaughlin, K. A., Nelson, C. A., III. (2012). Variation in neural development as a result of exposure to institutionalization early in childhood. *Proceedings of the National Academy of Sciences of the United States of America*, 109(32), 12927-12932. <https://doi.org/10.1073/pnas.1200041109>

⁷² Bernard, K., Simons, R., & Dozier, M. (2015). Effects of an attachment-based intervention on Child Protective Services-Referred mothers' event-related potentials to children's emotions. *Child Development*, 86(6), 1673-1684. <https://doi.org/10.1111/cdev.12418>

⁷³ Cicchetti, D., Rogosch, F. A., Toth, S. L., & Sturge-Apple, M. L. (2011). Normalizing the development of cortisol regulation in maltreated infants through preventive interventions. *Development and Psychopathology*, 23(3), 789-800. <https://doi.org/10.1017/S0954579411000307>

⁷⁴ Fisher, P. A., Van Ryzin, M. J., & Gunnar, M. R. (2011). Mitigating HPA axis dysregulation associated with placement changes in foster care. *Psychoneuroendocrinology*, 36(4), 531-539. <https://doi.org/10.1016/j.psyneuen.2010.08.007>

⁷⁵ Dozier, M., Peloso, E., Lewis, E., Laurenceau, J. P., & Levine, S. (2008). Effects of an attachment-based intervention on the cortisol production of infants and toddlers in foster care. *Development and Psychopathology*, 20(3), 845-859. <https://doi.org/10.1017/S0954579408000400>

- Child maltreatment is linked to increased neural salience of negative emotional faces.
- Child maltreatment is linked to hypoactivation of the HPA axis (underresponsive biological stress system).
- Poverty can exacerbate effects of child maltreatment on the developing brain and on cortisol. Unpredictability (food insecurity, neighborhood or household chaos) is linked to increased biological stress.
- For children in the CWS, intensive parenting interventions can help normalize day-to-day cortisol rhythms, which may promote future physical and mental health.

Session IV Questions

Claire Coles, Ph.D. (*Emory University*) noted that her research team had conducted imaging studies in children exposed to cocaine and alcohol that produced very similar results to those found in children experiencing poverty, suggesting that what is being assessed in all of these studies is stress and that whatever is causing stress is producing these nonspecific effects. This makes the cause of brain effects difficult to isolate in research.

- Dr. Tarullo agreed, adding that a further confounding factor is often that children are experiencing multiple stressors, and determining specific impacts of specific stressors can be very challenging.

Darcey Merritt, Ph.D. (*University of Chicago*) asked what the overarching term “maltreatment,” when used in the presentation of research findings, actually means, when the majority of children impacted by the CWS are impacted by contextual, poverty-related neglect. She noted that context is often not a consideration in studies, and asked what Drs. Manly and Tarullo do to ensure that research findings are understood.

- Dr. Manly reported that in MHFC research, comparison groups are often from the same communities and are also experiencing poverty. An additional way that MHFC addresses this issue is by not using CWS labels for neglect, given that many different experiences are often adjudicated as neglect. Instead, MHFC researchers try to specify what children’s actual experiences are and to subsequently examine the various stressors. There is significant overlap among children who are experiencing exposure to community violence and multiple forms of trauma, and it is very challenging to disentangle

different experiences. CWS terminology is also a challenge, because what is considered maltreatment within a child welfare context can differ by state or be equated to neglect. Language is very important, as well as the science of how different components are assessed before attempting to look at their relative contributions. The goal is to try to understand the experiences of children and families in the research and in the service systems.

- Dr. Merritt reiterated that child maltreatment is a very broad term encompassing so many different types of maltreatment, that when she reads results or views slides that state “child maltreatment is associated with ...” she feels that it is critical for researchers to find a way to articulate what type of maltreatment is actually associated with the outcome.
 - » Dr. Manly agreed, noting that one reason MHFC researchers created the maltreatment classification system was to try to capture all of the nuances involved in different individual experiences.
- (Name not provided) reiterated the importance of language in the presentation of results, stating that “when you show a slide that says child maltreatment leads to these things, that’s really sowing disinformation, because the category is too big.”
 - Dr. Manly noted that this is one reason it is so important to weigh risk and protective factors and state that there is no one outcome. There are many different forms of maltreatment and many different outcomes.
 - » Dr. Tarullo added that language is a limitation in existing literature, where most sample groups of “maltreatment” are very heterogeneous, so that within most studies that have been done, there is no option to tease apart different types of maltreatment and their impacts. One of the reasons there are many inconsistencies in published findings may be because samples are so heterogeneous and include individuals with many different experiences. Moving forward, an important research agenda should be to carefully select samples and characterize them more clearly.

Dr. Dettlaff asked Dr. Tarullo to discuss the effects of forcibly separating young children from their families on the developing brain.

- Dr. Tarullo reported that the forcible separation has traumatic effects on the brain. Whether separations are border separations or separations from a caregiver in the United States, attachment is critical. Humans are designed as a species to be with a consistent caregiver when young. Separation from a caregiver is very damaging to the brain; it causes toxic levels of stress. Charlie Zena has done a lot of work on a kind of foster system that takes both the need of a child to be in contact with attachment caregivers and the need for the child to bond with current caregivers into account. There are separation effects on the brain, but there are also questions of what the child is experiencing when separated. The quality of care provided by foster caregivers can make a difference.
 - Dr. Dettlaff asked why, given that the trauma of separation is so severe, the government is allowed to continue to forcibly separate hundreds of thousands of children every year.
 - » Dr. Tarullo noted that she would not be the right person to answer that question, because she does not even work in the child welfare field.

An audience participant asked what effects disruption in parent self-regulation have on co-regulation in infancy and where these effects may affect developmental processes, which could potentially lead to problems in child self-regulation and subsequent developmental sequelae.

- Dr. Manly indicated that, from a clinical intervention standpoint, helping families with co-regulation is important in child-parent intervention models. Parent self-regulation can be challenging for parents with their own histories of trauma, as is responding to their babies and toddlers to help them as they are learning self-regulatory practices and coping skills. There is a need to provide more support for families in addressing the parental history of trauma and in developing skills for successfully helping babies and toddlers to develop self-regulation.
 - (Name not provided) noted that this seemed particularly relevant in situations where parental substance use is involved; parent self-regulation

would likely be affected during periods of withdrawal or early sobriety, and this could add stress and strain to existing challenges.

- » Dr. Manly agreed that this was an important consideration, along with the changes in reward systems that occur and the possibility that parenting may not provide the same rewards for individuals with a history of trauma. There is a need to find better ways of supporting parents with a history of trauma as well as parents experiencing changes that occur with substance use that may impact parenting and the relationships with their children.

(Name not provided) noted her appreciation of Dr. Tarullo's nuanced subdivision of different types of poverty and asked about the relationship between outcomes Dr. Tarullo mentioned and income inequalities between societies.

- Dr. Tarullo noted that many aspects of poverty are co-occurring in individuals, and many studies look only at income or education level as a way of classifying experiences, despite the fact that income or education level could be proxies for other aspects of poverty. The first step is to measure thoroughly to look at the actual variable that is having an effect related to poverty. In children, income is a distal variable, and the effect might be due to something more relevant to their direct experience. Income inequality can be thought of in terms of inequalities between neighborhoods in the United States. Experiences are very different for individuals in neighborhoods where everyone has a similar income than they are for individuals who are the most disadvantaged in the neighborhood. Well-intentioned people can create situations like busing, where an unintended consequence can be a greater awareness of income inequality. Research on subjective social status in adults suggests that when individuals perceive themselves to be at the bottom of a social hierarchy, there are consequences for their executive functioning and brain activation. This would be difficult to assess in younger children who may not have a sufficient cognitive level to perceive social differences, but in older children and adolescents it is likely that there are also cognitive and brain activation consequences.

Session V: The Science on Children/Families in Child Welfare II

(Julie Poehlmann, Ph.D., University of Wisconsin; Tyreasa Washington, Ph.D., Child Trends; Cecilia Casanueva, Ph.D., Research Triangle Institute International)

Dr. Poehlmann introduced Dr. Casanueva, a Senior Public Health Researcher at Research Triangle Institute (RTI) International. Dr. Casanueva has done important work analyzing data from NSCAW, and evaluating the Infant-Toddler Court Program.

Research with the Child Welfare Systems: Challenges, Solutions, and Lessons Learned (Cecilia Casanueva)

Dr. Casanueva indicated that she would be presenting information that, in her perspective as a researcher, the HBCD study team would need if it had not previously worked with CWS, including:

- challenges in conducting CWS research
- examples of RTI's CWS research studies and NSCAW
- RTI's lessons learned across CWS studies

Challenge 1: Policy Variations

Given that the HBCD study will have 25 sites and one data set containing data from 7,500 children, the study team may want to consider how to integrate differences in state child welfare policies and child especially helpful as the HBCD study attempts to do so.^{76, 77, 78, 79} The example in Figure 16 illustrates the implementation of differential response policy by state in 2015, where states that had implemented policies that offer any alternate/differential response path to standard CWS investigation are indicated by green boxes and states that had not are represented by light blue boxes. Although the differential response paths also differ between states, typically they do not involve investigation, charges,

or substantiation and do attempt to connect individuals to services. welfare systems into modeling. Michelle Johnson-Montoyama, Ph.D., at Ohio State University has successfully integrated these differences and the interactions between them, and her work **may be**

In Figure 16, boxes outlined in red represent states that offer earned income tax credit (EITC) to families with children and an annual income below a set amount on top of the federal EITC. Black triangles are used as directional indicators of increase or decrease in child maltreatment reports for children under the age of 5 between 2015 and 2019. In Massachusetts, where both a differential response pathway and a state EITC were offered, reports of child maltreatment decreased overall during this time period, as illustrated in the column chart; however, when examined by county, illustrated in the map, the change in rates of child maltreatment reports varied a great deal. This suggests that factors at the county level, such as differences across child welfare agency and judicial practices, also play a significant role in the rate of child maltreatment reporting. One example of practical differences can be found in the way MAT is viewed in different jurisdictions. MAT is necessary to address chronic substance use for some individuals with SUD. However, some judges consider MAT to be the equivalent of continued drug use and not an acceptable form of recovery. Knowledge of these local nuances at different sites could be very helpful for HBCD researchers. In Session II, Dr. Kelly mentioned the SCAN policy database; state data regarding these policies can be easily downloaded and married with HBCD study data for use in modelling. The data user's guide for the SCAN database is available at https://www.ndacan.acf.hhs.gov/datasets/pdfs_user_guides/scan-usersguide.pdf. The SCAN data set also includes data on human trafficking, an important issue that may affect participants in the HBCD study. A number of youth run away from foster care; these youth are more likely to become victims of predators such as human traffickers. Pregnancy can occur, as well as coping through substance use.

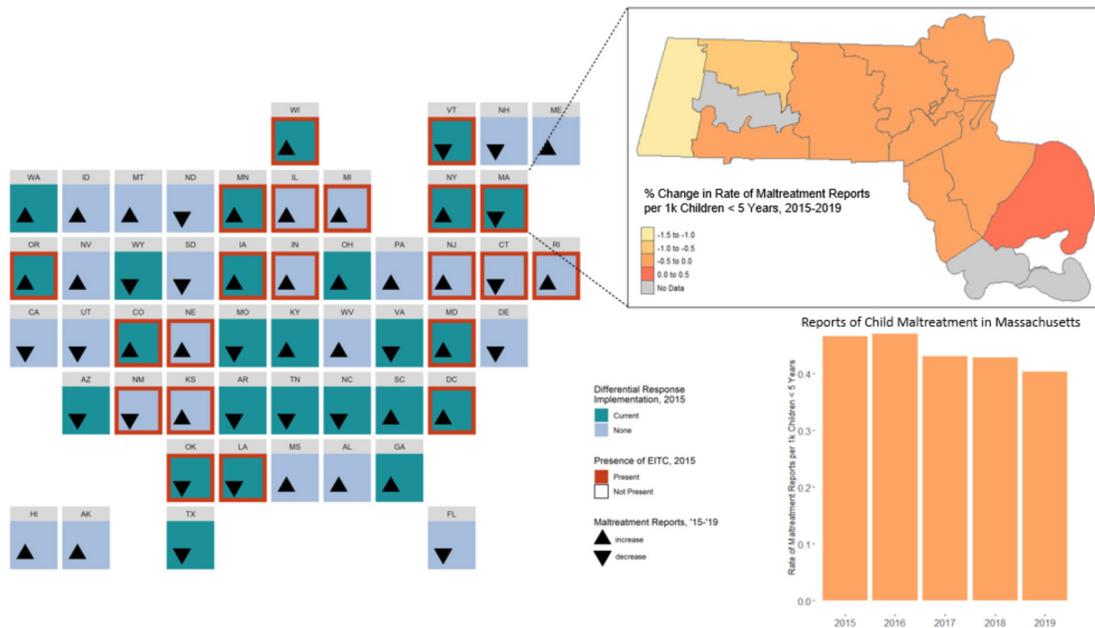
⁷⁶ Johnson-Motoyama, M., Ginther, D., Fluke, J., & Phillips, R. (2020). *Did differential response systems reduce child neglect and foster care entries in the U.S.? Results from a national study*. Society for Social Work and Research 24th Annual Conference, Washington, DC. <https://sswr.confex.com/sswr/2020/webprogram/Paper38688.html>

⁷⁷ Johnson-Motoyama, M., Ginther, D., Phillips, R., Beer, O., Merkel-Holguin, L., & Fluke, J. (2022). Differential response and the reduction of child maltreatment and foster care services utilization in the U.S. from 2004 to 2017. *Child Maltreatment*, 28(1), 152-162. <https://doi.org/10.1177/10775595211065761>

⁷⁸ Johnson-Motoyama, M., Phillips, R., Beer, O., & Damman, J. (2020). *Changing definitions of child abuse and neglect in the U.S.: A twelve year retrospective*. Society for Social Work and Research 24th Annual Conference, Washington, DC.

⁷⁹ Maguire-Jack, K., Johnson-Motoyama, M., & Parmenter, S. (2021). A scoping review of economic supports for working parents: The relationship of TANF, child care subsidy, SNAP, and EITC to child maltreatment. *Aggression and Violent Behavior*, Article 101639.

Figure 16. Differential Response Policies, State Refundable Earned Income Tax Credit, and Change in Child Maltreatment Reports



Challenge 2: Need for Data on Child and Family Strengths, Protective Factors, Concrete Needs, and Challenges

The FFPSA has been a significant milestone in child welfare in the United States. With the implementation of the FFPSA, there has been a change in the type of child welfare data that states are required to report in order to receive federal funding. For many years prior to the FFPSA, states focused on reporting data pertaining to maltreatment, substantiation of maltreatment allegations, removals, changes in placements, and permanency. The FFPSA has changed the conceptual frameworks that state CWSs use when working with families. States are beginning to use frameworks focused on strengthening families. Several states are applying the Strengthening Families™ Protective Factors Framework put forth by the Center for the Study of Social Policy⁸⁰ to prepare Family First Plans and restructure state CWSs. The logic model for this framework (Figure 17) includes protective factors, where families are supported to build things like parental resilience and knowledge of parenting and child development. Such protective factors are not yet reflected in the data reported by states; although they are required to report data on child and parent risk factors, they are not reporting data on protective factors. When HBCD

investigators meet with representatives of their local CWS, they are likely to be very interested in any study data pertaining to these protective factors.

Challenge 3: Need for Data on Evidence-Based Services and Interventions

In addition to requiring states to produce a Family First Plan in order to receive funding, the FFPSA also requires states to indicate specific interventions that will be used in the three key areas of substance use, mental health, and parenting and to include the evidence base for selecting these interventions. The scoring of intervention programs included in the Title IV-E clearinghouse can be very helpful in identifying interventions likely to be approved by the federal government. Unfortunately, very few scores exist for navigator services, particularly kinship navigators. These navigators are one of the focus points of the FFPSA legislation, and critical components in any state Family First Plan. Any data that HBCD can provide demonstrating the effectiveness of navigator systems would be helpful. The Title IV-E clearinghouse system is also limited in that many effective interventions are not scored in the clearinghouse because research demonstrating effectiveness has used a comparison group receiving an alternate intervention. Studies comparing an intervention to a control group receiving active treatment are not considered for the clearinghouse. More research is needed to fill these gaps in the clearinghouse.

⁸⁰ Center for the Study of Social Policy. (n.d.). About Strengthening Families™ and the Protective Factors Framework. <https://cssp.org/wp-content/uploads/2018/11/About-Strengthening-Families.pdf>

Challenge 4: Participatory Research vs. Researcher-Guided Design

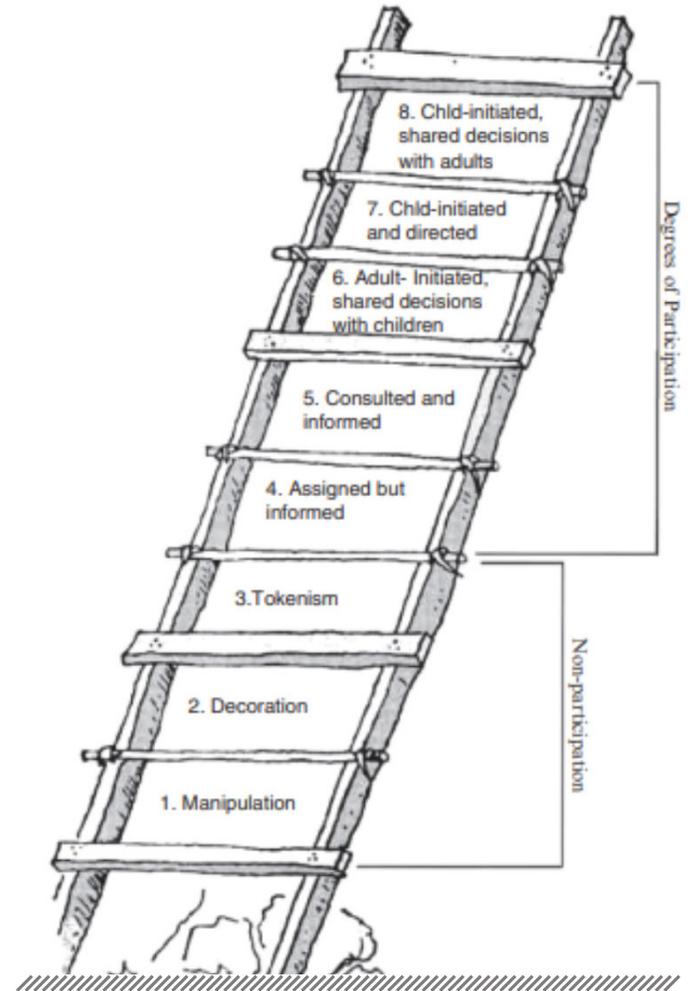
Many years ago, participatory research that incorporated perspectives from individuals with lived experience was an area of tremendous interest; however, the promise of participatory research and its implementation in the field have been very elusive. In April 2023, ACF organized a National Child Abuse and Neglect Conference, with a strong focus on the need for changes in the existing CWS. The conference addressed the importance of ending the traumatization of families, children and parents that occurs through contact with the CWS in order to better strengthen and support families, as well as the need to involve both parents and youth with lived experience in the process of change. Many presenters discussed the problem of tokenism in research, shown as the third rung on the Ladder of Participation in Figure 17.⁸¹ The Ladder of Participation, created several decades ago, serves to illustrate the eight proposed levels of youth participation, from manipulation to child-initiated activities involving shared decision-making with adults. Tokenism in research occurs when individuals with lived experience are invited to participate because their involvement is a requirement for funding, but are not truly integrated into the design and conduct of the research project. Researchers, including HBCD researchers, need to ensure true participation of individuals with lived experience and to communicate to these individuals that their experience is important and will be integrated into the work.

Challenge 5: State Initiatives vs Researcher Focus

Since the introduction of the FFPSA, 39 states have developed and received approval for their Family First plans. Examples of individual state initiatives to improve their CWS can be viewed in [Indiana's Supportive Communities, Resilient Families, Thriving Children Community Implementation Toolkit](#) and in the annual report on [Dependent Children in Washington State: Case Timeliness and Outcomes](#). Dr. Casanueva feels that an important questions that state CWS may have regarding the HBCD project pertains to how HBCD research integrates with state initiatives already in place and types of interventions already being applied.

⁸¹ Source: Hart, R. A. (2008). *Stepping back from 'The ladder': Reflections on a model of participatory work with children* (pp. 19-31). Springer. [Stepping-Back-from-The-Ladder-Reflections-on-a-Model-of-Participatory-Work-with-Children.pdf](#) (researchgate.net)

Figure 17. The Ladder of Participation



RTI Research

As mentioned in previous presentations, NSCAW includes a number of reports, briefs, and one-pagers. Across NSCAW I and NSCAW II, there have been hundreds of publications and conference presentations, and the OPRE NSCAW website provides a wealth of information on children involved with the CWS and their well-being. At the completion of NSCAW I, the data included more than 40,000 variables. Researchers must apply for access to NSCAW data; this requires submission of evidence of institutional review board (IRB) approval and a list of the individuals who will be working with the data. HBCD researchers may want to consider applying and using NSCAW data, which include indicators of depression, aggression, and developmental delay and many other topics relevant to HBCD. Data from NSCAW I, NSCAW II, and NSCAW III are archived ([NDACAN](#)) and detailed information about the survey design, manuals, and

codebooks are available for restricted release download to researchers who are approved to use the data. NDACAN also includes a database of references related to NSCAW and to secondary research. More information can be found at <https://www.ndacan.acf.hhs.gov/user-support/user-support-nscaw.cfm>.

One of the most important contributions of NSCAW has been providing researchers with the data needed to connect the dots among CWS, placement, safety, and permanency. Decades ago, the only focus of the CWS was child safety; in some courts, child well-being is still not prioritized, and safety of the child is the sole focus. NSCAW data have allowed researchers to demonstrate important connections between child well-being and out-of-home placement. Much of this research includes very sophisticated modeling, and longitudinal findings from NSCAW I and II have revealed that:

- Children with emotional and behavioral problems (EBP) are at higher risk of out-of-home placement.^{82, 83, 84, 85, 86, 87}
- Out-of-home placement is associated with negative psychological effects, including anxiety, depression, aggressive behavior,⁸⁸ and emotional dysregulation and negative academic outcomes.⁸⁹

- Children placed with kin have fewer EBP or have a decrease in EBP longitudinally as compared with children placed in foster care.^{90, 91, 92, 93, 94, 95, 96}
- Physical and sexual abuse maltreatment reports are associated with high EBP, trauma, depression, and negative academic outcomes, including lower executive functioning and lower reading and math achievement.^{97, 98, 99, 100, 101, 102, 103, 104}

⁸² Barth, R., Guo, S., Weigensberg, E., Christ, S., Bruhn, C., & Green, R. (2009). Explaining reunification and reentry 3 years after placement in out-of-home care. In M. Bruce Webb, K. Dowd, B. Jones Harden, J. Landsverk, & M. Testa (Eds.), *Child welfare and child well-being: New perspectives from the National Survey of Child and Adolescent Well-Being* (pp. 208-235). Oxford University Press. <https://academic.oup.com/book/26065>

⁸³ Barth, R. P. (2008). Kinship care and lessened child behavior problems: Possible meanings and Implications. *Archives of Pediatrics & Adolescent Medicine*, 162(6), 586-587. <https://doi.org/10.1001/archpedi.162.6.586>

⁸⁴ Barth, R. P., Lloyd, E. C., Green, R. L., James, S., Leslie, L. K., & Landsverk, J. (2007). Predictors of placement moves among children with and without emotional and behavioral disorders. *Journal of Emotional and Behavioral Disorders*, 15(1), 46-55. <https://doi.org/10.1177/10634266070150010501>

⁸⁵ Campbell, K. A., Thomas, A. M., Cook, L. J., & Keenan, H. T. (2012). Longitudinal experiences of children remaining at home after a first-time investigation for suspected maltreatment. *The Journal of Pediatrics*, 161(2), 340-347. <https://doi.org/10.1016/j.jpeds.2012.02.039>

⁸⁶ Foster, E. M., Millimeter, M. M., & Bai, Y. (2011). Explaining the disparity in placement instability among African-American and White children in child welfare: A Blinder-Oaxaca decomposition. *Children and Youth Services Review*, 33(1), 118-125. <https://doi.org/10.1016/j.childyouth.2010.08.021>

⁸⁷ O'Neill, M., Risley-Curtiss, C., Ayon, C., & Williams, L. R. (2012). Placement stability in the context of child development. *Children and Youth Services Review*, 34(7), 1251-1258. <https://doi.org/10.1016/j.childyouth.2012.02.018>

⁸⁸ Wiersma et al. (2012).

⁸⁹ Panlilio, C. C., Harden, B. J., & Harring, J. (2018). School readiness of maltreated preschoolers and later school achievement: The role of emotion regulation, language, and context. *Child Abuse & Neglect*, 75, 82-91. <https://doi.org/10.1016/j.chiabu.2017.06.004>

⁹⁰ Aarons, G. A., James, S., Monn, A. R., Raghavan, R., Wells, R. S., & Leslie, L.K. (2010). Behavior problems and placement change in a national child welfare sample: A prospective study. *Journal of the American Academy of Child and Adolescent Psychiatry*, 49(1), 70-80. <http://www.ncbi.nlm.nih.gov/pubmed/20215928>

⁹¹ Berger, L. M., Bruch, S. K., Johnson, E. I., James, S., & Rubin, D. (2009). Estimating the "impact" of out-of-home placement on child well-being: Approaching the problem of selection bias. *Child Development*, 80(6), 1856-1876. <https://doi.org/10.1111/j.1467-8624.2009.01372.x>

⁹² Roos, L. E., Kim, H. K., Schnabler, S., & Fisher, P. A. (2016). Children's executive function in a CPS-involved sample: Effects of cumulative adversity and specific types of adversity. *Children and Youth Services Review*, 71, 184-190. <https://doi.org/10.1016/j.childyouth.2016.11.008>

⁹³ Rosenthal, J. A., & Villegas, S. (2010). Living situation and placement change and children's behavior. *Children and Youth Services Review*, 32(12), 1648-1655. <https://doi.org/10.1016/j.childyouth.2010.07.003>

⁹⁴ Rubin, D., O'Reilly, A. L. R., Luan, X. Q., & Localio, A. R. (2007). The impact of placement stability on behavioral well-being for children in foster care. *Pediatrics*, 119(2), 336-344. <https://doi.org/10.1542/peds.2006-1995>

⁹⁵ Rubin, D. M., Downes, K. J., O'Reilly, A. L., Mekonnen, R., Luan, X., & Localio, R. (2008). Impact of kinship care on behavioral well-being for children in out-of-home care. *Archives of Pediatrics & Adolescent Medicine*, 162(6), 550-556. <https://doi.org/10.1001/archpedi.162.6.550>

⁹⁶ Wu, Q. (2017). Understanding kinship diversion and its relationship with child health and behavior problems. *Dissertation Abstracts International Section A: Humanities and Social Sciences*, 77(11-A(E)).

⁹⁷ Barboza, G. E., & Dominguez, S. (2017). Longitudinal growth of post-traumatic stress and depressive symptoms following a child maltreatment allegation: An examination of violence exposure, family risk and placement type. *Children and Youth Services Review*, 81, 368-378. <https://doi.org/10.1016/j.childyouth.2017.08.029>

⁹⁸ Coohy, C., Renner, L. M., Hua, L., Zhang, Y. J., & Whitney, S. D. (2011). Academic achievement despite child maltreatment: A longitudinal study. *Child Abuse & Neglect*, 35(9), 688-699. <https://doi.org/10.1016/j.chiabu.2011.05.009>

⁹⁹ Font, S. A., & Cage, J. (2018). Dimensions of physical punishment and their associations with children's cognitive performance and school adjustment. *Child Abuse & Neglect*, 75, 29-40. <https://doi.org/10.1016/j.chiabu.2017.06.008>

¹⁰⁰ Izzo, C., Smith, E., Biemer, P., & Christ, S. (2010). Latent classification of physical abuse as a predictor of adolescent functioning. In M. Bruce Webb, K. Dowd, B. Jones Harden, J. Landsverk, & M. Testa (Eds.), *Child welfare and child well-being: New perspectives from the National Survey of Child and Adolescent Well-Being* (pp. 107-132). Oxford University Press. <https://academic.oup.com/book/26065>

¹⁰¹ Voith, L. A., Gromoske, A. N., & Holmes, M. R. (2014). Effects of cumulative violence exposure on children's trauma and depression symptoms: A social ecological examination using fixed effects regression. *Journal of Child & Adolescent Trauma*, 7(4), 207-216. <https://doi.org/10.1007/s40653-014-0026-8>

¹⁰² Woodruff, K., & Lee, B. (2011). Identifying and predicting problem behavior trajectories among pre-school children investigated for child abuse and neglect. *Child Abuse & Neglect*(7), 491. <https://doi.org/10.1016/j.chiabu.2011.03.007>

¹⁰³ Yoon, S. (2017). Child maltreatment characteristics as predictors of heterogeneity in internalizing symptom trajectories among children in the child welfare system. *Child Abuse & Neglect*, 72, 247-257. <https://doi.org/10.1016/j.chiabu.2017.08.022>

¹⁰⁴ Yoon, S., Cage, J., Pei, F., & Barnhart, S. (2018). Risk and resilience factors for psychobehavioral symptom trajectories among child welfare-involved youth. *Journal of Interpersonal Violence*, <https://doi.org/10.1177/0886260518799485DOI:10.1177/088>

- Exposure to other types of violence community and family violence is associated with higher EBP across time.^{105, 106, 107}
- Children with chronic conditions, disabilities, and impairment are a greater risk of maltreatment longitudinally.^{108, 109, 110}
- Children with developmental delay in three or more areas have higher risk of a maltreatment re-report.¹¹¹

Lessons Learned Across RTI Child Welfare Studies

Across different RTI child welfare studies, some important lessons have emerged that are likely to also apply to HBCD. Local CWS agency buy-in for research is often a challenge. Some potential solutions to this challenge include:

- working with state and local universities—researchers in university social work program are often very interested in partnering with other researchers and have worked with the CWS for many years; these individuals can help to identify the right people to contact at a state and county level and can serve as champions for the ABCD project
- making first contact with the CWS through a trusted researcher or administrator known to the CWS agency
- wherever possible, identifying and integrating research questions of interest to the CWS agency
- preparing to meet with multiple layers of agency personnel to describe the study, answer questions, and obtain necessary endorsements or approvals

¹⁰⁵ Yoon, S., Kobulsky, J. M., Voith, L. A., Steigerwald, S., & Holmes, M. R. (2015). Gender differences in caregiver-child relationship mediation of the association between violence exposure severity and adolescent behavior problems. *Child Abuse & Neglect*, 50, 104-115. <https://doi.org/10.1016/j.chiabu.2015.10.012>

¹⁰⁶ Yoon, S., Tebben, E., & Lee, G. (2017). Early childhood aggression among child welfare involved children: The interplay between the type of child maltreatment and ecological protective factors. *Children and Youth Services Review*, 81, 72-80. <https://doi.org/10.1016/j.childyouth.2017.07.030>

¹⁰⁷ Yoon, S., Yoon, D., Wang, X., Tebben, E., Lee, G., & Pei, F. (2017). Co-development of internalizing and externalizing behavior problems during early childhood among child welfare-involved children. *Children and Youth Services Review*, 82, 455-465. <https://doi.org/10.1016/j.childyouth.2017.10.016>

¹⁰⁸ Helton, J. J., & Cross, T. P. (2011). The relationship of child functioning to parental physical assault: Linear and curvilinear models. *Child Maltreatment*, 16(2), 126-136. <https://doi.org/10.1177/1077559511401742>

¹⁰⁹ Helton, J. J., & House, N. G. (2019). Children with chronic health conditions and maltreatment re-report. *Children and Youth Services Review*, 105, Article 104412. <https://doi.org/10.1016/j.childyouth.2019.10.4412>

¹¹⁰ Kahn, J. M., & Schwalbe, C. (2010). The timing to and risk factors associated with child welfare system recidivism at two decision-making points. *Children and Youth Services Review*, 32(7), 1035-1044. <https://doi.org/10.1016/j.childyouth.2010.04.011>

¹¹¹ Perrigo, J. L., Berkovits, L. D., Cederbaum, J. A., Williams, M. E., & Hurlburt, M. S. (2018). Child abuse and neglect re-report rates for young children with developmental delays. *Child Abuse & Neglect*, 83, 1-9. <https://doi.org/10.1016/j.chiabu.2018.05.029>

Working with local CWS agencies is likely to take a great deal of time. CWS personnel are very overwhelmed, work very long hours, and may not communicate information with other personnel. It may be necessary to provide information multiple times to different layers of personnel.

Burden is also an important consideration. The COVID-19 pandemic has created a great deal of additional work for CWS personnel; many children were placed with kin who died, and many others have no remaining family to be placed with because of COVID-related deaths. Loss, trauma, and grief have affected many families, particularly families already dealing with poverty. Researchers can reduce any additional burden related to the HBCD study by building CWS compensation into site budgets, offering to embed researchers at the agency to extract data files, designating CWS liaisons, bundling and streaming study communications, and acknowledging and working around CWS agency's competing priorities. CWS turnover in personnel may be an issue. During the pandemic, some counties experienced annual CWS turnover of 120 percent. Researchers can avoid potential challenges related to CWS staff turnover by regularly identifying and meeting with new agency personnel to describe the study and share memorandums of understanding (MOUs) and data use agreements (DUAs) to provide context. Additional challenges and suggested solutions are listed in Table 1.

Examining the Strengths and Complexities of African-American Kinship Care Families (Tyreasa Washington)

Dr. Poehlmann introduced Dr. Washington, a Senior Program Area Director and Distinguished Senior Scholar for Child Welfare at Child Trends. Dr. Washington has experience in both academia and practice, having been both a professor and a licensed clinical social worker.

Dr. Washington began her career as a foster care social worker and, later, served as a supervisor in foster care. In these roles, she observed the difficulties experienced by children in foster care, including frequent changes in placement, placement in group homes, juvenile justice charges, and the trauma experienced by children when told that they were going to be separated from their parents. She also noticed that children placed with kin seemed to be faring better than others, sparking her research interest in kinship care. The term “kinship care” is used to refer to situations where relatives are raising

Table 1. Challenges and Solutions from Lessons Learned Across RTI Child Welfare Studies

Challenge	Solutions
Confidentiality laws	<ul style="list-style-type: none"> Review state rules for Disclosure of Confidential Child Abuse and Neglect Records, and discuss with the CWS partners (e.g., local universities) permitted to receive CWS data.
Records expungement	<ul style="list-style-type: none"> Review and integrate restrictions, detailed at https://www.childwelfare.gov/pubpdfs/registry.pdf, into data collection and research design.
CWS agency requirements for data sharing	<ul style="list-style-type: none"> Develop MOUs, DUAs, and/or IRB applications tailored to requirements. Assume that each state and some counties may require their own MOU/DUA. Be aware that many state agencies have their own IRBs that must approve the study. Build in sufficient time for these activities.
Selection of instruments and methods of administration that do not negatively affect participant response rates	<ul style="list-style-type: none"> Engage individuals with lived experience. For agency-level measures, engage current or former agency personnel in the development and testing of instruments. For child/family-level measures, engage children and families with lived experience to design and pretest instruments. Explore options for multiple modes of administration to allow for participant preferences and greater flexibility.
Tracking of legal guardianship over time	<ul style="list-style-type: none"> Engage CWS agency liaisons or case supervisors to identify and/or make contact with legal guardians. Create tailored study materials for legal guardians.
Location of participants for follow-up	<ul style="list-style-type: none"> Work with CWS agency liaisons to obtain current contact information. Conduct panel retention between waves of data collection.

children when the parents are unable or unwilling to do so. Formal kinship care occurs when children involved with the CWS are formally placed with a relative. This type of kinship care, sometimes called “public kinship care” or “kin foster care” is supervised by the CWS. Informal kinship care occurs when children are placed with relatives, but this placement is not supervised. These children may have been brought to the attention of the CWS and undergone an investigation with allegations dismissed, or may not have been involved in the CWS at all. Most often, kinship care refers to grandparents raising their grandchildren, but the term can also refer to children being raised by any relative or individual with a kin bond, such as a godparent or church member.

For every one child raised by kin in the foster care system, there are approximately 18 children outside of the foster care system who are being raised by kin (informal kinship care).¹¹² More than 2.5 million children are being raised by a relative or close family friend with no parent living in the household, including 133,873 children in the foster care system. This number has recently decreased for the first time since the COVID-19 pandemic; however, this may be because of a decrease in reporting rather than a decrease in children in kinship care. In 2010,

26 percent of children in foster care were being raised by relatives; this number increased to 34 percent in 2020. Between 2020 and 2022, the total number of children in the United States living in kinship care was 2,529,000; of these children, 982,000 lived in one of 10 southern states (Figure 18).¹¹³

While kinship care is common in all races and cultures, it is more common among African-American children than any other racial or ethnic group. Approximately 20 percent of African-American children reside with relatives at some point in their lives. Some scholars suggest that disproportionately high numbers of African-American children in kinship care can be traced to the adaptations of the African-American community to ongoing racial and economic oppression dating back to the era of slavery, when families were forcibly separated from their children.^{114, 115, 116, 117} Many African-American

¹¹³ Source: The Annie E. Casey Foundation Kids Count Data Center. (2023). Children in kinship care in United States. <https://datacenter.aecf.org/data/bar/10455-children-in-kinship-care?loc=1&loc2=2#1/any/false/2479/any/20160>

¹¹⁴ Billingsley A., & Giovannoni, J. M. (1972). *Children of the storm: Black children and American child welfare*. Harcourt, Brace, Jovanovich.

¹¹⁵ Fuller-Thomson, E., & Minkler, M. (2000). African American grandparents raising grandchildren: A national profile of demographic and health characteristics. *Health & Social Work, 25*(2), 109-118. <https://doi.org/10.1093/hsw/25.2.109>

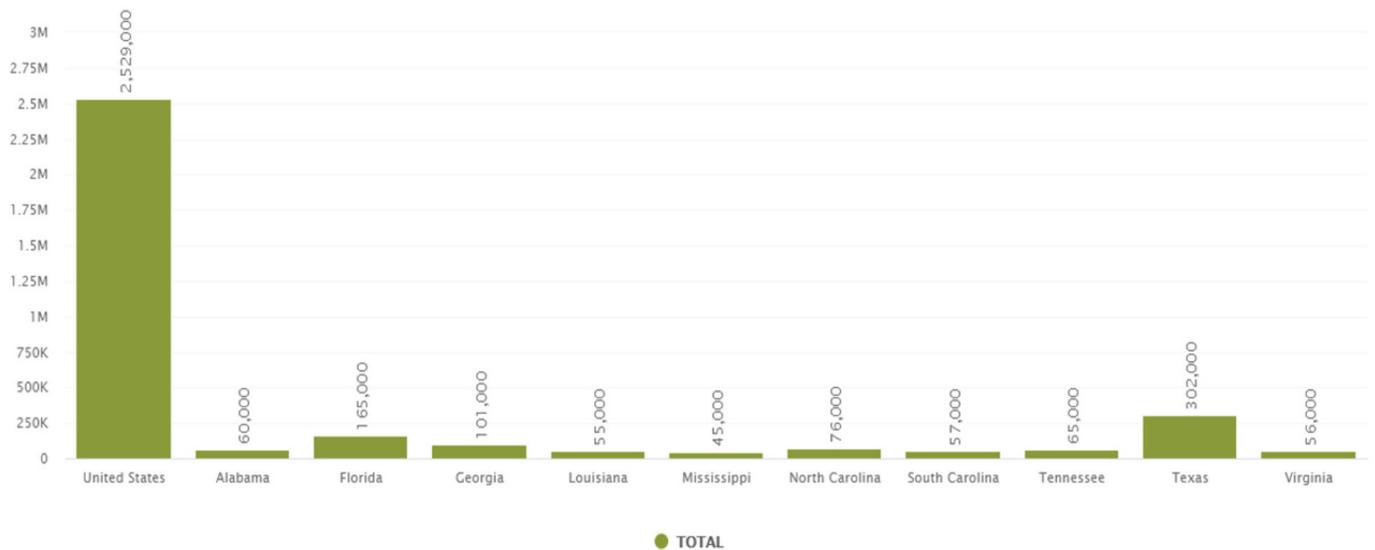
¹¹⁶ Hill, R. B. (1977). *Informal adoption among Black families*. National Urban League Research Department.

¹¹⁷ Smith, C. J., & Devore, W. (2004). African American children in the child welfare and kinship system: From exclusion to over inclusion. *Children and Youth Services Review, 26*(5), 427-446. <https://doi.org/10.1016/j.childyouth.2004.02.005>

¹¹² Grandfamilies & Kinship Support Network. (2022). Kinship/grandfamilies strengths and challenges. <https://www.gksnetwork.org/resources/grandfamilies-kinship-families-strengths-challenges/>

Figure 18. Children in Kinship Care Across 10 Southern States

CHILDREN IN KINSHIP CARE (NUMBER) - 2020-2022



families have used kinship care as a means of upward mobility, relocating to areas with better opportunities and leaving children with kin in the South. Kinship care is still used for upward mobility, but it is also used as a means to address parental substance use, incarceration, and mental illness, as well as teen pregnancy.^{106, 118, 119, 120, 121} Although the term “kinship care” is new, the practice is not. Dr. Washington grew up on farmland that included her house, her grandmother’s house, and her aunt’s house. Later, another aunt moved in across the street. Dr. Washington’s grandmother raised two of her grandchildren from birth and a third grandchild for approximately 7 years. Dr. Washington had a first cousin she called Uncle Keith, and her father referred to his own first cousin as his baby brother. None of this was called kinship care at the time, but it was common practice in the African-American community.

Racial inequities exist in the CWS. Structural racism has several definitions, including the following by the Urban Institute:¹²²

“Structural racism refers to the historical and contemporary policies, practices, and norms that create and maintain white supremacy, by segregating racial/ethnic communities from access to opportunity and upward mobility by making it more difficult to secure quality education, jobs, housing, health care, and equal treatment in the criminal justice system.”

Structural racism is apparent in the economic, housing, and criminal justice systems. Very recently, the Internal Revenue Service admitted that Black taxpayers were more likely to undergo an audit, confirming a previous Stanford University study that found that Black taxpayers were up to five times more likely to be audited.^{123, 124} Homes in

¹⁰⁸ Hill, R. B. (1999). *The strengths of African American families: Twenty-five years later*. University Press of America.

¹⁰⁹ McAdoo, H. P. (2001). Parent and child relationships in African American families. In N. B. Webb (Ed.), *Culturally diverse parent-child and family relationships: A guide for social workers and other practitioners* (pp. 89-105). Columbia University Press.

¹²⁰ Gleeson, J. P., Wesley, J. M., Ellis, R., Seryak, C., Talley, G. W., & Robinson, J. (2009). Becoming involved in raising a relative’s child: Reasons, caregiver motivations and pathways to informal kinship care. *Child & Family Social Work, 14*(3), 300-310. <https://doi.org/10.1111/j.1365-2206.2008.00596.x>

¹²¹ Gleeson, J. P., Wesley, J. M., Ellis, R., Seryak, C., Talley, G. W., & Robinson, J. (2009). Becoming involved in raising a relative’s child: Reasons, caregiver motivations and pathways to informal kinship care. *Child & Family Social Work, 14*(3), 300-310. <https://doi.org/10.1111/j.1365-2206.2008.00596.x>

¹²² <https://gflec.org/initiatives/national-financial-capability-study/>

¹²³ Rappeport, A. (2023, May 16). I.R.S. acknowledges Black Americans face more audit scrutiny. *The New York Times*. <https://www.nytimes.com/2023/05/15/us/politics/irs-black-americans-tax-audit.html>

¹²⁴ Elzayn, H., Smith, E., Hertz, T., Ramesh, A., Fisher, R., Ho, D. E., & Goldin, J. (2023). *Measuring and mitigating racial disparities in tax audits* [working paper]. Stanford University Institute for Economic Policy Research. <https://siepr.stanford.edu/publications/measuring-and-mitigating-racial-disparities-tax-audits>

Black neighborhoods are valued 21 to 23 percent lower than homes in other areas and are 1.9 times more likely to be appraised below contract price.¹²⁵ In both the adult and the juvenile justice systems, African-Americans are more likely to be incarcerated than other individuals when they commit similar crimes. African-American males receive 20 percent longer sentences and more in-prison disciplinary infractions; they have lower odds of parole and greater odds of death penalty introduction when compared with White males convicted of similar crimes.¹²⁶ ¹²⁷ In the CWS,¹²⁸ Black children are more likely to be reported, investigated, and adjudicated as victims of child abuse and neglect,¹²⁹ removed from families and placed into foster care,¹³⁰ and to be legally, permanently separated from their birth parents (parental rights terminated).¹³¹

Dr. Washington's research focuses on ways that kinship care addresses racial inequalities and examines the factors that promote the well-being of African-American kinship care families. In research conducted to identify the promotive factors of African-American kinship care on children's social and academic competence in 143 African-American informal kinship care families, Dr. Washington found that greater access to resources, higher family functioning, and birth parent involvement were positively associated with children's social and

academic competence.^{132, 133} Stress among kinship caregivers may lead to cardiovascular symptoms, Alzheimer's disease, and depression. Dr. Washington and colleagues have found that some caregivers experience high levels of stress and engage in maladaptive coping behaviors, and, often, children in kinship care reminded caregivers to take care of themselves by attending doctor's appointments or going to the nail salon. Some caregivers prioritized their own needs by engaging in positive self-care behaviors, including exercise and listening to jazz and gospel music.¹³⁴ Financial stability is also a stressor for many African-American informal kinship care families. In an study combining data from an exploratory, sequential mixed-methods pilot study with data from the [National Financial Capability Study](#), Dr. Washington's team found that most families were struggling financially and reporting that family resources were only seldom or sometimes adequate to provide for basic household needs. Caregivers also reported being unaware of public benefits and community resources available for kinship care families and giving up on seeking these resources because of difficulties in navigating the system.¹³⁵ When pilot data were compared with data from a demographically matched sample of U.S. households in the National Financial Capability Study, results indicated that families providing informal kinship care were less secure than other families based on three indicators of financial stability. Families providing informal kinship care were:

1. less able to cover their usual household expenses
2. less likely to have income that exceeded expenses
3. less likely to have emergency savings.

Ongoing research includes two mixed-methods studies funded by the *Eunice Kennedy Shriver* National Institute of Child Health and Human Development. The first examines the social, academic, and behavioral outcomes of African-American children in both formal and informal kinship care, and the second is looking at stress reduction and cardiovascular health to reduce the risk of Alzheimer's

¹²⁵ Rothwell, J., & Perry, A. M. (2022). *How racial bias in appraisals affect the devaluation of homes in majority-Black neighborhoods*. Brookings Institution. <https://www.brookings.edu/research/how-racial-bias-in-appraisals-affects-the-devaluation-of-homes-in-majority-black-neighborhoods/>

¹²⁶ American Civil Liberties Union. (2014, October 27). *Written submission of the American Civil Liberties Union on racial disparities in sentencing: Hearing on reports of racism in the justice system of the United States submitted to the Inter-American Commission on Human Rights, 153rd Session*. https://www.aclu.org/sites/default/files/assets/141027_iachr_racial_disparities_aclu_submission_0.pdf

¹²⁷ The Sentencing Project. (2018). *Report to the United Nations on racial disparities in the U.S. criminal justice system*. <https://www.sentencingproject.org/reports/report-to-the-united-nations-on-racial-disparities-in-the-u-s-criminal-justice-system/#footnote-ref-16>

¹²⁸ See White, S. A., & Persson, S. (2022). Racial discrimination in child welfare is a human rights violation—Let's talk about it that way. American Bar Association. <https://www.americanbar.org/groups/litigation/committees/childrens-rights/articles/2022/fall2022-racial-discrimination-in-child-welfare-is-a-human-rights-violation/>

¹²⁹ Kim, H., Wildeman, C., Jonson-Reid, M., & Drake, B. (2017). Lifetime prevalence of investigating child maltreatment among US children. *American Journal of Public Health, 107*(2), 274-280. <https://doi.org/10.2105/AJPH.2016.303545>

¹³⁰ Minoff, E., & Citrin, A. (2022). *Systemically neglected: How racism structures public systems to produce child neglect*. Center for the Study of Social Policy. <https://cssp.org/resource/systemically-neglected/>

¹³¹ Guggenheim, M. (2022, Winter). The failure to repeal the Adoption and Safe Families Act will long be a stain on this period of American history. *Family Integrity and Justice Quarterly*. <https://publications.pubknow.com/view/752322160/54/>

¹³² Washington, T., Gleeson, J. P., & Rulison, K.L. (2013). Competence and African American children in informal kinship care: The role of family. *Children and Youth Services Review, 35*(9), 1305-1312. <https://doi.org/10.1016/j.childyouth.2013.05.011>

¹³³ Washington, T., Cryer-Coupet, Q. R., Coakley, T. M., Labban, J., Gleeson, J. P., & Shears, J. (2014). Examining maternal and paternal involvement as promotive factors of competence in African American children in informal kinship care. *Children and Youth Services Review, 44*, 9-15. <https://doi.org/10.1016/j.childyouth.2014.05.019>

¹³⁴ Washington, T., Walton, Q. L., Kaye, H., Sung Hong, J., & Cook, B. (in press). Exploring self-care practices of African American informal kinship caregivers. *Child & Family Social Work*.

¹³⁵ Washington, T. & Despard, M. (under review). Improving African American kinship care families outcomes: The importance of financial stability. *Children and Youth Services Review*.

Disease in African-American kinship care caregivers. In all research, Dr. Washington works to balance scientific rigor with the inclusion of lived experience.

A significant body of research suggests that children living with kin exhibit more favorable behavioral and mental health outcomes than children placed with nonrelated foster parents.^{136, 137, 138} Children in kinship care benefit from stability, family connection, and maintenance of their culture and tend to have better academic outcomes than children in traditional foster care. In an analysis of four longitudinal administrative data sources merged to create a sample of 519,306 racially diverse youth (27 percent African-American, 12 percent Latinx, 53 percent White) in North Carolina schools aged 8 to 11 years, Dr. Washington and colleagues examined academic trajectories of children in out-of-home care to determine whether kinship care provided a protective effect relative to traditional foster care.¹³⁹ Academic performance was assessed using standardized test scores. Findings revealed that the academic performance of children in traditional foster care was poorer than that of their peers in formal and informal kinship care, and that the academic performance of children in formal foster care was similar to that of children in non-out-of-home care. Dr. Washington and her colleagues believe this suggests that for children in out-of-home care, living with relatives and provision of formal support and services are beneficial. It is important to remember that for every one child in formal kinship care receiving support and services, there are approximately 18 living in informal kinship care. This is a very large group of children in out-of-home care who do not receive support and services through the CWS. A system for supporting these families, providing individuals who can attend Individualized Education Plan meetings, and linking children and families to mental health, substance use treatment, and other valuable services. A small number

of studies indicate that children in kinship care may also be at increased risk of substance use and pregnancy¹⁴⁰ as well as delinquency¹⁴¹ during adolescence relative to peers in nonkin foster care. However, there is longitudinal evidence that the conditions children are exposed to prior to living with kin may account for poorer functioning, and functioning tends to improve over time while in kinship care.^{142, 143} Dr. Washington and other scholars believe that for children in out-of-home care, placement with kin is a protective factor for children's outcomes. Preliminary findings from a historical analysis of 134,263 diverse (30 percent Black/African-American, 11 percent Hispanic/Latin, 49 percent White) North Carolina youth who entered the 10th grade in 2010 suggest that, although youth in nonkin and informal kinship care initially appeared to have significantly higher school dropout rates, when data were controlled for middle school disengagement factors (exam performance, grade retention, absences, and suspensions), youth demographics, and background characteristics, differences between youth in any out-of-home placement and youth not involved in the CWS were eliminated.¹⁴⁴

The mission of Child Trends is to improve the lives and prospects of children and youth by conducting high-quality research and sharing the resulting knowledge with practitioners and policymakers. To achieve this, Child Trends produces research aimed at reducing child poverty and mitigating the effects of poverty and financial hardship on children and their families, and includes a racial equity lens in all research and communications work.¹⁴⁵ Child Trends provides services and is conducting additional research related to kinship care. The Grandfamilies & Kinship Support Network Technical Assistance Center, funded by the U.S.

¹³⁶ Gleeson, J. P. (2017). Kinship care for children and young people: International perspectives. In P. Dolan & N. Frost (Eds.), *The Routledge handbook of global child welfare* (chapter 18). Routledge. <https://doi.org/10.4324/9781315672960>

¹³⁷ Winokur, M., Holtan, A., & Batchelder, K. E. (2014). Kinship care for the safety, permanency, and well-being of children removed from the home for maltreatment. *Cochrane Database of Systematic Reviews*, Issue 1, Article CD006546. <https://doi.org/10.1002/14651858.CD006546.pub3>

¹³⁸ Washington, T., Wrenn, A., Kaye, H., Priester, M., Columbo, G., Carter, K., Shadreck, I., Hargett, B. A., Williams, J. A., & Coakley, T. (2018). Psychosocial factors of behavioral health outcomes among children in roster and kinship care: A systematic review. *Children and Youth Services Review*, 90, 118-133. <https://doi.org/10.1016/j.childyouth.2018.04.030>

¹³⁹ Washington, T., Steward, C. J., & Rose, R. (2021). Academic trajectories of children in formal and informal kinship care. *Child Development*, 92(6), 2299-2316. <https://doi.org/10.1111/cdev.13580>

¹⁴⁰Sakai, C., Lin, H., & Flores, G. (2011). Health outcomes and family services in kinship care: Analysis of a national sample of children in the child welfare system. *Archives of Pediatrics & Adolescent Medicine*, 165(2), 159-165. <https://doi.org/10.1001/archpediatrics.2010.277>

¹⁴¹ Ryan, J. P., Marshall, J. M., Herz, D., & Hernandez, P. (2008). Juvenile delinquency in child welfare: Investigating group home effects. *Children and Youth Services Review*, 30, 1088-1099. Ryan, Hong, Herz, & Hernandez, 2010

¹⁴² Barth, R. P., Guo, G., Green, R. L., & McRae, J. (2007). Developmental outcomes for children in kinship and nonkinship care: Findings from the National Survey of Child and Adolescent Well-Being. In R. Haskins, F. Wulczyn, & M. Webb (Eds.), *Child protection: Using research to improve policy and practice* (pp. 187-206). Brookings Institution Press. <https://www.jstor.org/stable/10.7864/j.ctt6wplfh6>

¹⁴³ Rubin, D. M., Downes, K. J., O'Reilly, A. L., Mekonnen, R., Luan, X., & Localio, R. (2008). Impact of kinship care on behavioral well-being for children in out-of-home care. *Archives of Pediatrics & Adolescent Medicine*, 162(6), 550-556. <https://doi.org/10.1001/archpedi.162.6.550>

¹⁴⁴ Rose, R., Washington, T., Stewart, C., & Malley, K. (in progress). The risk of drop out among youth in formal and informal kinship foster care.

¹⁴⁵ <https://www.childtrends.org/research-topic/poverty-economic-wellbeing>

Administration for Community Living, provides technical assistance to a wide array of tribal, state, and territorial government agencies, as well as nonprofit organizations that serve kinship families. The Philadelphia Community technical assistance project, funded by the William Penn Foundation, provides funding to eight organizations in Philadelphia to help them strengthen and broaden their services for kinship care families, and the Therapeutic Kinship Foster Care pilot study is testing a public-private partnership to implement kinship therapeutic foster care. Dr. Washington serves as a subject matter expert for the Grandfamilies & Kinship Support Network Technical Assistance Center, and is co-principal investigator for the Philadelphia Community project.

Session V Questions

(Name not provided) noted her appreciation for the attention paid to the language used in many presentations, specifically the use of “impacted by CWS” rather than “involved in the CWS.” In her work, parents have stated that they prefer “impacted” to “involved,” given that they are not voluntarily involved with the CWS. She also noted her appreciation for the reminder of the importance of paying attention to the lived experience of individuals involved in the CWS, and recommended the use of “protective and risk” in place of “risk and protective” to emphasize a focus on strengths and resilience, rather than on deficits. She suggested that meeting participants seek more information regarding anti-racist and anti-oppressive research and science.

Dr. Schlafer asked Dr. Washington to talk briefly about where she sees the balance of the harms of surveillance in formal kinship placements with the potential benefits, such as financial and other services and supports.

- Dr. Washington stated that she would like to hear perspectives from formal kinship caregivers who have experienced both surveillance and services and supports. The small number of individuals who have raised this issue with Dr. Washington have expressed that they are nervous because social workers are coming into the home, and are unsure if the child will be taken away at any time when they are not doing something correctly. They feel that they do not have the privilege to make the same mistakes

that birth parents do. Dr. Washington believes that many children are moved out of formal kinship care situations when it is not necessary. She emphasized that she is not suggesting more children should be placed in foster care; rather, for children who are able to stay in their communities and reside with kin, support should be provided. It is important to ask families what they need in terms of support. In some cases, family members with limited levels of education are afraid to meet with the child’s teachers and don’t know what to ask when they do meet with teachers. Partnerships with individuals who have more experience in working with teachers and others could benefit kinship caregivers, in addition to badly needed economic support.

Dr. Gurka noted that Dr. Washington’s presentation had reported that children placed in kinship care had higher numbers of teen pregnancies and substance use than their peers, and asked if this might be because of a higher number of children placed in kinship care who had parents with SUDs or teen pregnancies. Dr. Gurka also asked whether positive outcomes for children in kinship care might be related to an increased likelihood of positive involvement of birth parents relative to children in traditional foster care.

- Dr. Washington indicated that studies reporting teen pregnancy and substance use outcomes had not been her studies, so she could not comment on how analyses were performed or how long the participants had been in kinship care. She noted that the studies had worked with adolescents and that in her own and other research studies, children who remained in care longer tended to have better outcomes. For example, children placed with kinship caregivers at ages 5, 6, 7, or 8 who remain in care through adolescence are likely to have better adolescent outcomes than individuals who were placed in kinship care as adolescents. Decades of longitudinal research demonstrates that children placed in kinship care exhibit improved behaviors over time. It is possible that the few studies reporting negative outcomes may have been affected by the children’s experiences prior to being placed in kinship care, their age at the time of placement, and the length of time they had been in kinship care. Dr. Washington also reported

that stipulations that do not allow interaction with birth parents can be placed on kinship care. This can be very challenging for grandparents providing care, who still love their own child regardless of CWS inquiries or substance use issues. It is likely that some visitations occur without the foster system's awareness. Research results indicate that birth parents matter, and communication and a friendly relationship with birth parents are important. Dr. Crumbley has done extensive work with kinship care families and has pointed out that there can be challenges when birth parents are involved. Sometimes birth parents miss visits because they are homeless or have other limitations. The perspective of grandparent kinship caregivers also shift because their grandchild is now the top priority, rather than the birth parent, and they may withdraw support previously provided to the birth parent in order to care for the grandchild.

Dr. Jones-Harden asked Dr. Casanueva to share a few findings from the Safe Babies Court Team approach.

- Dr. Casanueva indicated that, often, research conducted on infant courts has not received sufficient funding to include a comparison group and that in her work, they use propensity score matching to create a similar group for comparison from the NSCAW II database. This was done in previous research by Kim McCombs-Thornton, Ph.D. Dr. Casanueva's research comparing data from more than 10 infant courts to data from NSCAW II found, as did Dr. McCombs-Thornton's research, that children who participated in the Safe Babies Court Team program (Safe Babies) were more likely to reach permanency and to reach foster permanency and that reunification was the most common type of permanency achieved. However, where Dr. McCombs-Thornton found that for both

the Safe Babies group and the NSCAW I group approximately 20 percent of children did not reach permanency, Dr. Casanueva's research 10 years later indicated approximately 17 percent of children in the NSCAW II comparison group and only 2 percent of children in the Safe Babies group did not reach permanency. Dr. Casanueva's team also compared families who entered Safe Babies in the year prior to the COVID-19 pandemic to families who entered Safe Babies during the pandemic and was surprised to find that the percentage of children in need of services who received services was approximately 98 percent for both groups, and the time to receipt of services was shorter for families during the COVID-19 pandemic. They hypothesized that this was because of the increased use of telehealth during the pandemic, which also extended Safe Babies into rural areas, where it was previously very difficult to get specialized services, such as those for children with developmental problems. A memorandum from ACF describing lessons learned during the COVID-19 pandemic includes the utility of telehealth. Safe Babies developed many creative solutions to the limitations created by the pandemic, including the provision of devices and mobile hotspots to parents in rural areas to enable participation in hearings and family team meetings remotely. In some cases, this was not enough, as devices malfunctioned or were lost. Safe Babies began installing devices for parents in community locations, including local libraries where parents could use library private rooms for remote participation. Many community coordinators established partnerships with local telephone service providers to provide phones and access points and with other organizations to distribute food, diapers, infant formula, and other donated items.

Session VI: Racial/Ethnic Disparities in Child Welfare

*(Brenda Jones Harden, Ph.D., University of Maryland;
Alan Dettlaff, Ph.D., University of Houston; Darcey Merritt, Ph.D., University of Chicago;
Cary Waubanascum, Ph.D., University of Wisconsin–Green Bay)*

Dr. Jones Harden opened Session VI, noting that presentations would be focused on the differential experiences of children from minoritized backgrounds in the child welfare system (CWS). She indicated that in her opinion, sometimes researchers, policymakers, and practitioners live in silos and are not always aware of the complexities in the CWS, and she suggested that any participants finding these complexities overwhelming should imagine what families experience. Disparities exist across multiple child-serving systems but are particularly pernicious in the CWS, in part because the CWS serves children that every other system fails and the effects of racial and ethnic disparities may be compounded over time and multiple systems. Researchers should consider not only disparities in outcomes but also disparities in the experiences of children in the CWS, as these are especially important to document in the HEALthy Brain and Child Development (HBCD) Study and will certainly affect outcomes.

Dr. Jones Harden introduced the Session VI presenters—Dr. Dettlaff, who is a Professor of Social Work at the University of Houston; Dr. Merritt, Professor at the University of Chicago’s Crown Family School of Social Work, Policy, and Practice; and Dr. Waubanascum, Assistant Professor at the University of Wisconsin–Green Bay.

Racial Disparities and the Racist Legacy of the American Child Welfare System *(Alan Dettlaff)*

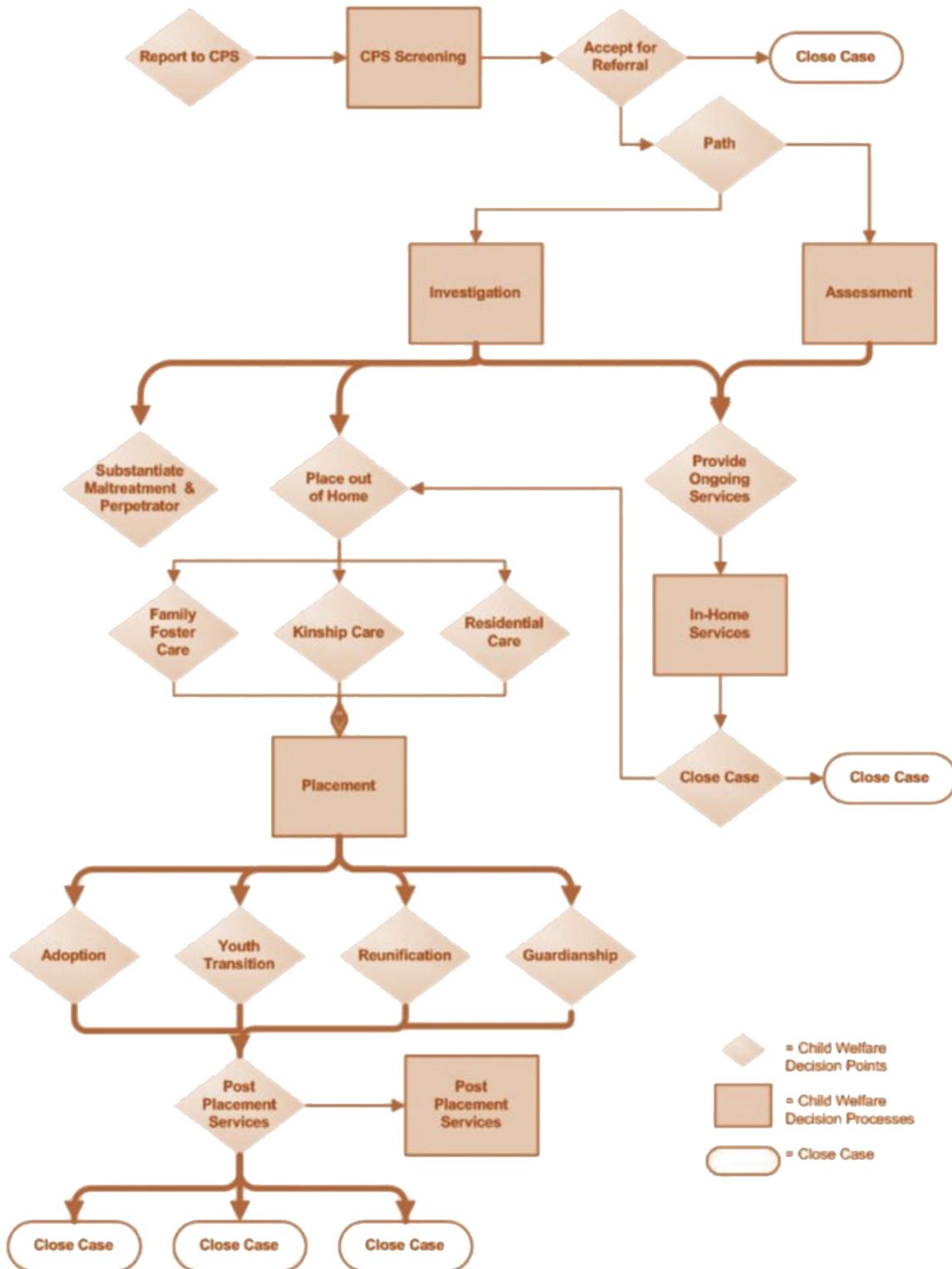
Dr. Dettlaff provided an overview of racial disproportionality and disparities in the CWS. “Disproportionality” means the state of being out of proportion; “racial disproportionality” can mean that a racial group in the system is overrepresented or underrepresented. Typically, racial disproportionality in the CWS refers to the overrepresentation of one group of children in the foster care system in relation to that group’s proportion in the general population. Disproportionality has most significantly affected Black children in the CWS; at a national level, Black children represent approximately 15% of the general population but approximately 25% of children in care. White children and Latinx children are both slightly

underrepresented in care, and Native American/Indigenous children are very overrepresented in care, constituting 1% of the general population but 2.7% of children in care. Despite these numbers, little is known about the experience of Indigenous children in the CWS. There is a greater body of knowledge regarding the experiences of Black children, and this is because Black children are overrepresented at both the federal level and in 46 out of 50 states.

Although Latinx children are underrepresented in the foster care system at the federal level, they were overrepresented in approximately 20 states in 2020, an increase from overrepresentation in 10 states in 2010. Racial disproportionality has been known to the CWS for 60 years. In 1972, Andrew Billingsley and Jeanne M. Giovannoni wrote a book called *Children of the Storm: Black Children and American Child Welfare*, about the overrepresentation of Black children in the CWS. Marian S. Harris’s book on the same topic, *Racial Disproportionality in Child Welfare*, was published in 2011, and Dr. Dettlaff served as Editor of the journal *Racial Disproportionality and Disparities in the Child Welfare System* in 2021. Although the topic has been covered in the literature for more than 60 years, the problem has remained relatively unchanged.

Racial disparities also exist in the CWS. Rather than comparisons between the proportion of one group in the system and the proportion in the general population, disparities are differences within the CWS among different groups. Black children are more likely to be reported for maltreatment, substantiated for maltreatment, and forcibly separated from their homes than White children and are less likely to exit foster care to reunification, tending to stay in foster care for longer periods of time. Figure 19 presents a flowchart of CWS decisions and processes. At each decision point represented by a diamond in Figure 19, Black children are more likely to experience poorer outcomes than other children. Each difference between Black children and other groups at points of entry or exit from the CWS creates the overrepresentation of Black children in care (disproportionality).

Figure 19. Decisions and Processes in the Child Welfare System



There are many theories regarding why racial disproportionality and disparities exist in the CWS. Proposed factors contributing to disproportionality and disparities include structural racism within society, biases within the system, and other factors. In the United States, forcible separations of Black children from their parents have been used as a means of maintaining White supremacy for more than 400 years. Historical accounts describe between one-third and two-thirds of Black children experiencing some form of family separation during the time of slavery. Different accounts describe Black infants separated from their mothers because slavers were annoyed by the infants' crying and Black infants beaten to death because their presence was an impediment to the sale of their mothers. Separation was the cruelest form of punishment at the disposal of slavers, and the threat of family separation was used to maintain the subjugation of enslaved individuals and prevent uprisings. Slavers were aware that separation was traumatic and denied that it was happening; this trauma was used as a spark for the abolition movement, particularly among empathetic White individuals in the North. Images of separations were common in anti-slavery newspapers disseminated throughout the North, but it was the image and account of separation documented in Harriet Beecher Stowe's *Uncle Tom's Cabin* that overcame remaining public apathy. *Uncle Tom's Cabin* was the second-most widely purchased book in the 19th century, surpassed only by the Bible. The depictions of family separation in the book were so influential on the growth of the abolition movement that upon meeting Harriet Beecher Stowe, Abraham Lincoln noted that she was the woman who wrote the book that started the Civil War. For the United States at the time of the Civil War, family separation and slavery were viewed as moral and societal failures that could be ended only through abolition.

After the 13th Amendment abolished slavery, policies were put into place to maintain the subjugation of Black people in the United States. Immediately after abolition, Black codes were passed, denying voting rights to Black people, making unemployment a crime for Black people, and turning crimes that had been misdemeanors into felonies when committed by Black people. In essence, this created a system of forced labor for Black people through imprisonment and convict leasing programs. The *Plessy v. Ferguson* Supreme Court decision of 1896 affirmed the constitutionality of these and, later, Jim Crow

laws, which remained until 1964. Although 1964 marked the end of legal segregation, the outcomes of these laws persist today in the areas of poverty, health and stress, and geographic contexts. Black and brown Americans are significantly affected by income and wealth gaps—as well as health disparities, including both mental and physical health impacts of the daily experience of racism, and geographical factors, such as racial residential segregation and discriminatory housing policies. These elements all contribute to some of the conditions that increase the likelihood of CWS contact for Black children and families.

The CWS is also responsible for some of the disproportionalities and disparities that exist today. The origin of the CWS began with orphan trains, which resettled poor and orphaned White children from the Northeast into the West in a system similar to the foster care system today. Black children were excluded from this system. After the orphan train movement ended, the Social Security Act of 1935 established Aid to Families with Dependent Children (AFDC), which provided poverty relief programs to White widowed mothers. As increasing numbers of Black individuals became eligible for poverty relief programs, the states established eligibility requirements, such as “man in the house” rules, which resulted in the expulsion of tens of thousands of Black families from welfare rolls in Southern states in the late 1950s and early 1960s. Use of these clauses was barred by President Eisenhower's 1960 executive order called the Flemming Rule, which also required state investigation of families removed from welfare rolls. These investigations of Black families by a primarily White workforce led to an influx of Black families in foster care, creating initial disproportionality in the CWS. The Public Welfare Amendments of 1962 further established foster care as a means of providing help to children living in poverty. In the same year, C. Henry Kempe's publication of “The Battered-Child Syndrome” led to the establishment of state mandatory reporting laws in all 50 states between 1963 and 1968. In 1962, there were approximately 500 reports of child abuse to the police in the U.S.; by 1968, 11,000 reports were made. In 1968, approximately 45% of calls made to state reporting hotlines were made regarding Black children and families, who represented approximately 8% of the population at that time. Disparities were solidified with the passage of the Child Abuse Prevention and Treatment Act (CAPTA) in 1974 despite 10 years of research indicating that mandatory reporting laws would

disproportionately harm Black children and families. The establishment of mandatory reporting laws occurred during—and may have been influenced by—the Civil Rights Movement and the publication of U.S. Assistant Secretary of Labor Daniel Patrick Moynihan’s report titled “The Negro Family: The Case for National Action.”

Today, 53% of Black children will be subject to a family policing investigation by the time they turn 18. Black children are forcibly separated from their parents at a rate nearly double that of White children; in some states, this is closer to three times the rate of White children. One in 11 Black children will be forcibly separated from their parents by the time they turn 18, and in some states, this rate is closer to 1 in 8. Dr. Dettlaff noted that these numbers are an indication of a pattern: In policy implementation throughout American history, when White power is threatened, the threat is responded to with White rage, seen through actual acts of violence, such as those during slavery and the Civil Rights era, but also through laws and policies, such as the Black codes and Jim Crow laws.

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Dr. Dettlaff also provided several quotations from psychologists regarding family separation. Dr. Erin Dunn of Massachusetts General Hospital’s Center for Genomic Medicine stated:

“The scientific evidence against separating children from families is crystal clear. No one in the scientific community would dispute it. It’s not like other topics where there is more debate among scientists. We all know it is bad for children to be separated from caregivers. Given the scientific evidence, it is malicious and amounts to child abuse.”

A statement from the American Academy of Pediatrics indicated that “to pretend that separated children do not grow up with the shrapnel of this traumatic experience embedded in their minds is to disregard everything we know about child development, the brain, and trauma,” and a quotation from Dr. Charles Nelson, Professor of Pediatrics at Harvard Medical School, read, “The effect is catastrophic. There’s so much research on this that if people paid attention at all to the science, they would never do this.” Each of those statements was made in 2018, after the U.S. Attorney General announced implementation of a zero tolerance policy for attempted illegal entry and illegal entry into the United States by a noncitizen. As a result of this policy, 3,000 children were forcibly separated from their parents, and statements such as the ones above were publicly made, equating family separation with torture. Dr. Dettlaff indicated that currently, the CWS separates 3,000 children from their families each week and that any study focused on healthy brain development should also focus on the impact of family separation on brain development.

Conclusions that can be drawn from outcomes for children in foster care are complicated by a difficulty in identifying an appropriate comparison group. Many studies compare children in foster care with children in the general population, which does not account for any trauma experienced by children prior to foster care entry. However, a growing number of research studies do include a comparison group, such as studies including a group that experienced similar forms of maltreatment but stayed in the home, sibling studies in which one child stayed in the home, and studies using propensity score matching. These studies indicate that children who experience foster care experience two to three times higher delinquency rates, higher teen birth rates, and lower earnings as adults; are twice as likely to have learning disabilities and developmental delays, six times more likely to have behavioral problems, and more likely to have substance-related disorders, psychotic disorders, bipolar disorder, depression, and anxiety disorders; have arrest rates two to three times higher than others; and are more likely to receive criminal convictions for violent offenses. Those are the outcomes of foster care for all children; however, the disproportionate involvement of Black children in the foster care system results in a disproportionate amount of harm. The foster care system may not be more harmful for any one racial or ethnic group, but given that Black

and brown children in America are already at risk of all of these outcomes, the addition of a foster care system that produces these outcomes increases the likelihood that these outcomes will occur for these children. Dr. Dettlaff indicated that these are the issues in American society that maintain oppression and subjugation of Black and brown people and that the foster care system is creating and perpetuating these conditions.

Dr. Dettlaff posed the following questions for consideration:

- Can a system that began with a racist intent evolve into a system that achieves racial equity?
- Can decades of racist policies be revised to no longer produce racist outcomes?
- Is racial equity an appropriate goal for a system that produces harm?

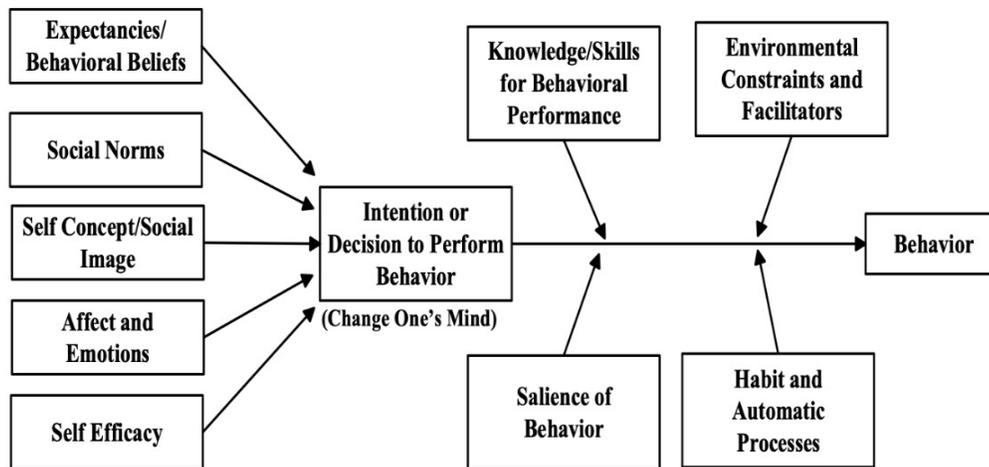
He reported that the answer to all three questions is “no.” The CWS is currently focused on the importance of achieving racial equity in the system. Racial equity makes sense as a goal if disproportionality is the problem, but proportionate involvement means that children are still separated from their parents every year. With racial equity, separation and related harms are just distributed equitably by race. It is important to think beyond racial equity to the root cause of the harm caused by the CWS with forcible and involuntary separation of children from their families.

Racism and Inequities in Child Poverty Surveillance: Black Families ‘Catch ACS Cases’ Disproportionately (Darcey Merritt)

Dr. Merritt indicated that she would be presenting on the experience of Black moms interfacing with the CWS. She explained that “catch ACS cases” is institutionalized/ carceral language she learned from mothers she has interviewed and that “ACS” can be used interchangeably with “CWS.” She further noted that the abbreviation CPS, often used for “child protective services,” could also be thought of as representing “child poverty surveillance.”

As discussed during Day 1 of the workshop, 76% of children who have interactions with the CWS on any given day do so because of allegations of neglect. This is primarily poverty-related neglect and racialized poverty-related unintentional neglect, not physical or sexual child abuse. Dr. Merritt’s project, “An Elicitation Analysis

Figure 20. Perspectives on Neglect Decision Theoretic



of Parental Perspectives Regarding Child Neglect,” is supported by an R21 from the Eunice Kennedy Shriver National Institute of Child Health and Human Development and has resulted in several publications.^{146, 147, 148} The project has two aims:

- To elicit and describe mothers’ perspectives on two specific types of child neglect, supervisory and physical child neglect, using qualitative methods; and
- To identify factors that shape mothers’ parenting decisions with respect to neglect, with an emphasis on their preexisting cognitions and schemas about parenting, using quantitative methods.

To achieve the second aim, Dr. Merritt has employed a decision theoretic (Figure 20) to understand how mothers make decisions based on their experiences, such as those involving case workers coming to mothers’ homes and expecting them to behave a certain way. Data have been gathered and analyzed according to a phenomenological approach rooted in grounded theory in two phases. Phase 1 included in-depth interviews of a small sample of clinicians (n=12) and mothers (n=11) to gather information for the elicitation analysis survey in Phase 2. Initially, Dr. Merritt intended to use an in-person survey for Phase 2, but the COVID-19 pandemic necessitated the use of an electronic survey, developed by the benefit LLC Ker-

twang. Survey development began with qualitative interviews and co-design sessions with a focus group of Black mothers with experience with the CWS to select appropriate terminology. Dr. Merritt’s group also employed a Black mother with lived experience, Cecilia, to guide parents through the interactive electronic survey and ensure that they feel safe, as the survey questions can be triggering for some individuals. In the survey application, Cecilia asks each question through prerecorded video, and respondents can record audio answers. The survey asks mothers how they would react in certain common scenarios. For example:

Sandra has three children, ages 2, 11, and 13. She was offered an extra late-night shift that would pay overtime. The extra pay would help her cover the rent, which she’s behind on. She has no one except her 13-year-old to watch her kids right now.

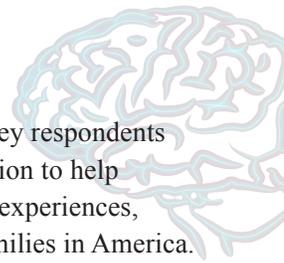
Put yourself in Sandra’s shoes.
What would you do?
You’ll have the chance to explain your answer.

This sample scenario was derived from the lived experiences of mothers who were being admonished by CWS caseworkers because they did not have appropriate child care and had to make the decision to leave their children home alone or with questionable supervision in order to do something critical to survival. Either decision could have negative consequences, such as homelessness because of unpaid rent or challenges from the CWS for leaving children home with a sibling.

¹⁴⁶ Merritt, D. H. (2020). How Do Families Experience and Interact with CPS? *The ANNALS of the American Academy of Political and Social Science*, 692(1), 203-226. <https://doi.org/10.1177/0002716220979520>

¹⁴⁷ Merritt, D.H. (2021). Documenting experiences and interactions with Child Protective Services. In J.T. Spartz & J. Siers-Poisson (Eds.), Preventing child maltreatment and neglect in the United States: Opportunities for Change, *Focus on Poverty*, 37(2), 3-10. Institute for Research on Poverty. <https://www.irp.wisc.edu/resource/documenting-experiences-and-interactions-with-child-protective-services/>

¹⁴⁸ Merritt, D. H. (2021). Lived experiences of racism among child welfare-involved parents. *Race and Social Problems*, 13, 63-72. <https://doi.org/10.1007/s12552-021-09316-5>



Each respondent receives \$50 upon completion of the survey. More than 400 surveys have been completed, but they have to be reviewed to eliminate bots and scammers. Currently, there are 92 valid surveys. Using the data collected, Dr. Merritt’s team will create a taxonomy to determine the basis on which mothers make one decision versus the other.

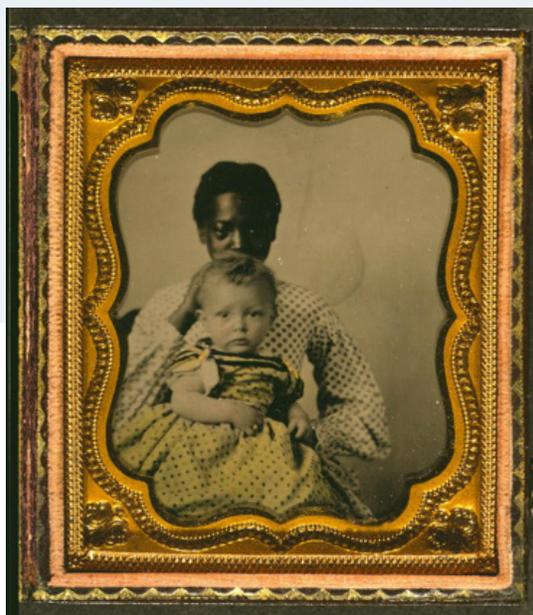
Dr. Merritt included quotations from survey respondents throughout the remainder of her presentation to help illustrate important aspects of participant experiences, along with a pictorial history of Black families in America.



“I thought when child welfare comes, you lose your kids. Once they get involved ... I just gave up because to me, you’re going to lose your kids ... The slave days when they put us on a block and separated us and changed our name ... child welfare is the same thing ... separating families ... just like slavery days, same thing, same outcomes.” — Mom 4



“You can’t even tell your kids why they can’t go with you. ‘No, Mommy. I want to go with you. No, Mommy. I want to go with you, Mommy.’ ... One is on the ankle. One is on the arm. ... Then here come these people ... to rip your kids off of you, screaming as we did on the slave trade block. ... Same experience at the visit.” — Mom 4



Historically and currently, Black mothers have been raising White babies and children and have been called “the help.” This raises an important question: If Black mothers are equipped to raise White children, why are they not considered equipped to raise their own? If the CWS had existed when Black mothers worked in cotton fields and had to choose between bringing their children to work or leaving them alone, these mothers would have faced consequences for putting their children in dangerous situations in the cotton field or for leaving them without appropriate supervision.

Dr. Merritt’s work is all underpinned by the reality that racism exists within American systems. She feels there is a need to reimagine the CWS in terms of its purpose and whether it is appropriate to address the issues that many families face. Racial disproportionality proliferates in oppressive organizations and cannot be disentangled from these lived experiences of racism. Racial disparities are grounded and born in the processes of systemically oppressive organizations, and lower socioeconomic status cannot be disentangled with lived experiences of racism and oppression or from the accompanying oversight of these organizations. Racism is a mechanism by which the racial disproportionality in CPS is evidenced through reporting and placement decisions. Dr. Merritt believes that systems such as the CWS are racist by design, given the way that the United States was founded. Structurally racist and oppressive societal and environmental contexts are the backdrop of all U.S. systems, and these are only loosely heeded by the CWS, particularly with regard to Black families. Racism continues to manifest in all structurally oppressive systems and most social and human organizations and agencies, including the CWS. Dr. Merritt feels that the inherent race-based inequities are systemically supported and perpetuated by all processes of these systems. Lived experiences and perceptions of racism amid systems involvement are related to being among the lower echelons of our society with diminished access to power, knowledge, and optimal resources. Dr. Merritt’s work addresses racialized poverty-related neglect. Racism is the driver of concentrated racialized poverty, which leads to racial disproportionality in the CWS. Racism and racial bias lead to poverty, which leads to neglect, which leads to surveillance and reporting.

Issue: Surveillance

Dr. Merritt shared a video clip to illustrate the type of scrutiny Black mothers are subject to in CPS. In the video, a Black mother hid her partner and all of the gifts he had given to the family from a visiting social worker. Upon discovering the man hiding in a closet, the social worker

began to question his role and level of support for the family. Dr. Merritt noted that mothers she had interviewed were required to keep receipts and documentation to prove that they had taken their children to therapy sessions or to the doctor or had purchased healthful food. These mothers must navigate the world while always being mindful that people are going to check on them and require supporting evidence to determine how mothers are living their lives and taking care of their families. Dr. Merritt reported that as a Black mother, she developed secondary trauma from conducting the research interviews, which included statements such as the following:

“I know what it means to have caseworkers coming to your house and everybody’s looking over everything and living under a microscope.” — *Mom 2*

“Well, you can’t avoid it, because we’re [oversurveilled], right? And we are in too many mandatory reporters’ eyes, right? What we need to do is change the way parents, family are responded to in crisis. ... We’ve got to change the response from punitive responses to responses that actually work towards healing and keeping families together and ... mitigating their crisis. The response normally is penalizing families for even having their crisis.” — *Mom 4*

“It’s just, you being watched. I mean, I hate to say it like that ... but you have to move differently ... accordingly because there’s always someone watching you. ... If I make one wrong move, like, that’s it ... and I’m stuck in this situation. ... I think money definitely has a lot to do with it. ... One of the first things she said to me was, ‘I see that you used to receive food stamps.’ ... So I’m already on your radar. I know how it works. ... You’re looking to people that are already poor or qualify for government assistance.” — *Mom 9*

“I didn’t know people can get services without having a CPS case. ... Won’t get services unless you catch a CPS case. But if kids are in foster care, they get everything. ... I have to give up my rights to get services and care. What about the struggling parents who have their kids?” (*Not attributed.*)

The story of Amy (name changed) illustrates the punitive nature of responses in the CWS to families and individuals in crisis. Amy came to the attention of the CWS because her 9-year-old son was consistently truant from school, and she was having difficulties taking care of her home and providing for her children. Amy had been raped and was suffering from emotional and physical trauma. The rape occurred two blocks away from her son's school, and Amy found it difficult to walk him past the trauma scene to school. Her depression was debilitating and paralyzing, interfering with her ability to care for her home and family. Amy confided in her doctor while receiving treatment for emotional and physical injuries related to the rape, as well as her son's teacher, that she was afraid and feeling triggered every time she tried to take him to school. Amy's children were removed by the CWS and not returned to her for five years. Amy stated:

"I kind of put myself at a disadvantage, which I know might sound crazy, but I mean, seeking help, the mental help that I was seeking and the physical help that I was seeking from my doctors and trying to be honest with my doctors about what was going on with me, I opened my whole world up for that, like, just that extra layer of surveillance.

"There's a lot of stigma surrounding mental health in the community that I grew up in. So, you know, I thought I was doing the right thing, but I do believe I put myself kind of at a disadvantage, because it took me so long to get my children back. It took me, you know, yeah, a long time, almost five years, to get my children back."

There is so much stigma in the Black community around mental health that just asking for help can be an accomplishment. Outcomes like Amy's are unlikely to encourage her to ask for help in the future. After asking mothers to describe what has happened to them, Dr. Merritt also asks who would have approved of their choices and who would not have approved and why. When Amy was asked these questions, she indicated:

"The doctor comes to mind because I went for help and I was honest in my struggle, my mental struggle, that it was hard at the time for me to take care of the children because of what I was going through. I was struggling to ... meet all their level of needs. I was struggling, and instead of helping, I was, you know, punished. I was punished because he was a mandated reporter. I was punished because they didn't recognize the trauma, and the same goes for the teachers that struggled with ... truancy, as far as my eldest not making it to school, but never offering an alternative.

"But they come to mind because every place that we turned ... every place that a person such as I can turn to in the city for help can also be that place that hurts us the most—because every professional, anybody that's connected in a professional realm, is a mandated reporter and they don't understand. ... Everybody is that nail to that hammer everywhere you go, so you struggle. You struggle to ask for help because help is scary."

Dr. Merritt also asks participants what emotions they had during their experience. Amy responded:

"Fear, of losing my children, pure terror when I lost them. Yeah, fear. At every turn, every walk through every room that they had to inspect, every refrigerator they had to open, toilet they had to flush, just fear ... shame because I got to that point that I couldn't provide for my children properly—although I ... always had ... guilt that I lost my children ... anger at the fact that ... this was done to me and I didn't feel as though any of it was my fault but I was paying the biggest price."

There is an ongoing debate in the research field regarding the meaning of evidence and the relative value of qualitative versus quantitative evidence. Both are incredibly valuable, and one should not be considered more important than the other. Researchers can obtain unique contextual and interpretive information through qualitative accounts of individual realities and experiences, and this information complements and extends what can be demonstrated through quantitative data. Dr. Merritt’s research is grounded in an intentionally antiracist and anti-oppressive approach to project and assessment design, incorporating insights from people with lived experiences, because she does not have the same lived experiences, even as a Black mom. Intentional involvement of individuals with lived experiences is essential to ensuring that research is not causing additional harm. A key consideration in antiracist science is left out variable error (LOVE), particularly error created by the inability to include measures of racism inherent in certain methodologies and data sets. Dr. Merritt called upon researchers to pause, understand, assess, and support parental behaviors with a thoughtful consideration of unintentional neglect and to avoid dictating rules of behavior to individuals suffering from decades of disenfranchisement and marginalization in their efforts to raise their children. Researchers need to reflect upon the fact that interaction with the CWS is traumatic—particularly for people with histories of structural oppression, discrimination, and racism—and remember that ongoing surveillance affects behaviors. Research must be historically aware, sensitive, and considerate of advocacy action, intentionally assessing every family with an antiracist and social justice lens; instead of asking “What did you do?” researchers should ask, “What happened to you?”

“So, We’ve Been Taken Away Since Forever”: Indigenous Relative Caregivers’ Experiences as a Framework for Uncovering Coloniality in the Child Welfare System (Cary Waubanasum)

Dr. Waubanasum introduced herself in her Oneida language, noting that she is a citizen of the Oneida Nation of Wisconsin and is of the Turtle Clan. The Oneida Nation is a matrilineal society. Dr. Waubanasum is also of three other tribes in Wisconsin. She is a Wisconsinite and an Assistant Professor at the University of Wisconsin–Green Bay. Dr. Waubanasum indicated that she brought with her the experiences of many of her ancestors,

including grandparents who were survivors of boarding schools. They all experienced historical trauma, and Dr. Waubanasum is a survivor of intergenerational trauma. She is also a beneficiary of their intergenerational love and traditional kinship structures and is a relative caregiver, a mother to two children and an aunt to eight nephews. In the Oneida language, the word for “aunt” is the same as the word for “mother”; that is an example of the Oneida kinship. The teachings of Dr. Waubanasum’s ancestors have informed the way she walks through this life and how she cares for the children in her life. The Oneida are relational people who share stories, and an awareness of shared experiences prompted Dr. Waubanasum’s interest in Indigenous people’s experiences with the CWS. Her work uses qualitative research to ask Indigenous relative caregivers how they experience the CWS. Dr. Waubanasum shared the following introduction from a submitted manuscript:

For hundreds of years, settler governments have violently removed Indigenous people from our mothers. First, we were forced from our Mother Earth (lands). Then we were abducted from the mothers who birthed us, forced into carceral boarding schools, and adopted far away from our homes.

Indigenous families experience high levels of child removal by the CWS compared with other racialized groups, and these high rates of removal persist more than 40 years after the implementation of the federal Indian Child Welfare Act (ICWA). There is ongoing coloniality in the CWS, premised on separation, removal, and ongoing colonial violence. Separation has been a practice since settlers first arrived on Native lands, beginning with removal of Native people from their lands. ICWA is currently being challenged in the U.S. Supreme Court. Dr. Waubanasum noted that Indigenous people are racialized; there has been much discussion of race and ethnicity, but not of tribal sovereignty. Dr. Waubanasum is a citizen of a sovereign tribal nation, and ICWA is based on this distinction, not on race. Justice Neil Gorsuch is a champion of tribal sovereignty; more information on his stance is available at <https://www.scotusblog.com/2022/11/closely-divided-court-scrutinizes-various-provisions-of-indian-child-welfare-act> and <https://www.youtube.com/watch?v=0J9sfp8VPuE>.

Dr. Waubanasum's study of Indigenous caregiver experiences was based on a scoping literature study completed in 2018,¹⁴⁹ which revealed evidence of disparities in the CWS and a glaring lack of Indigenous voices with lived experiences within the CWS. A more recent examination of publications on lived Indigenous experiences has implicated settler governments as perpetrators of colonial violence and harm,^{150, 151, 152, 153, 154} these findings are consistent with the results of Dr. Waubanasum's study.

Dr. Waubanasum provided a brief history of Indigenous child removal in the U.S. and Canada, given that Indigenous people do not recognize colonial borders. In the late 1800s, carceral boarding "schools" and residential "schools" ("schools" is most likely not an appropriate descriptor, given grave sites that have been unearthed and linked to these institutions) were established, with a focus on assimilation to White colonial culture that was grounded in Christianity, English, individualism, and citizenship and included child removal, separation, and kidnapping/abduction. Dr. Waubanasum's great-grandmother, who spoke fluent Oneida, was placed in one of these schools, and her language was beaten out of her. Violence against Native land also hurts Indigenous people deeply and emotionally, and this is why Native people are fierce protectors of their lands and waters. Dr. Waubanasum's family members have long protected the Wolf River, which runs through Wisconsin, against miners. Land has always been central in the colonization of Native people. In 1887, the Dawes Act was passed. This broke communally held tribal lands apart into individual allotments. Anna Laurens Dawes, daughter of the author of the Dawes Act, Senator Henry Dawes, was the first person to call for the development of a social work profession. She was also a member of several standing committees

with Captain Richard Henry Pratt, designer of the boarding school for forced assimilation; the emergence of social work and federal policies to control Native people and their lands were entangled during this period in history. Family education programs were implemented to train men to farm newly allotted lands and impose the Western role of caring for the household on Native women, while Native children were taken and put into boarding schools. In the 1950s and 1960s, the Indian Adoption Project in the U.S. and the Sixties Scoop in Canada, along with the Child Welfare League of America, carried out nearly 800 forced adoptions. Sandy White Hawk has conducted research and published accounts of her own and others' lived experiences of forced adoption and later repatriation home to their people.¹⁵⁵ Child removal has generated historical trauma, historical unresolved grief, and intergenerational trauma for Indigenous people.¹⁵⁶

"Coloniality" can mean several different things in different fields. Anibal Quijano has talked about the coloniality of power¹⁵⁷ as the intersection of world capitalism and racism, wherein racism is defined as a biological construct imposed upon people to create hierarchy of superior versus inferior. Maria Lugones has expanded upon the coloniality of power to include the modern colonial gender system,¹⁵⁸ stating that the concept of gender has been imposed as much as race, with gender as a distinct, dichotomous, hierarchical logic separate from race that has been imposed as a human characteristic. The colonial gender system established the White, Christian, heterosexual, land-owning man as superior to all others and all others as aberrations. All of this normative judgment provided justification for colonial violence among several civilization projects. Madina Tlostanova and Walter Mignolo extended the coloniality of power model to a colonial matrix of power model, which is based on the premise that in order for one society to gain control and power over another, it needs to completely erase the existing society. When White settlers arrived in the Americas, complex societies existed among the Native inhabitants of the land. They learned the concept

¹⁴⁹ Haight, W., Waubanasum, C., Glesener, D., & Marsalis, S. (2018). A scoping study of Indigenous child welfare: The long emergency and preparations for the next seven generations. *Children and Youth Services Review, 93*, 397-410. <https://www.sciencedirect.com/science/article/abs/pii/S0190740918304080?via=ihub>

¹⁵⁰ Navia, D., Henderson, R. I., & First Charger, L. (2018). Uncovering colonial legacies: Voices of Indigenous youth on child welfare (dis)placements. *Anthropology & Education Quarterly, 49*, 146-164. <https://doi.org/10.1111/aeq.12245>

¹⁵¹ Robertson, S. C., Sinclair, C., & Hatala, A. R. (2022). Indigenous mothers' experiences of power and control in child welfare: Families being heard. *Journal of Social Work, 22*(2), 303-322. <https://doi.org/10.1177/14680173211009187>

¹⁵² Cross, S. L., Day, A. G., & Byers, L. G. (2010). American Indian grand families: A qualitative study conducted with grandmothers and grandfathers who provide sole care for their grandchildren. *Journal of Cross-Cultural Gerontology, 25*(4), 371-383. <https://doi.org/10.1007/s10823-010-9127-5>

¹⁵³ Crofoot, T., & Harris, M. S. (2012). An Indian child welfare perspective on disproportionality in child welfare. *Children and Youth Services Review, 34*, 1667-1674. <https://www.sciencedirect.com/science/article/abs/pii/S0190740912001867?via=ihub>

¹⁵⁴ Tajima, E. A., Day, A. G., Kanuha, V. K., Rodriguez-Jenkins, J., & Pryce, J. A. (2022). What counts as evidence in child welfare research? *Research on Social Work Practice, 32*, 514-520. <https://doi.org/10.1177/10497315211069549>

¹⁵⁵ White Hawk, S. (2015, May 19). First Nations Repatriation Institute: Restoring First Nations people to their homelands. Retrieved from: https://turtletalk.files.wordpress.com/2015/06/1524-white_hawk_sandy.pdf

¹⁵⁶ Brave Heart, M., Chase, J., Elkins, J., & Altschul, D. (2011). Historical trauma among Indigenous peoples of the Americas: Concepts, research, and clinical considerations. *Journal of Psychoactive Drugs, 43*(4), 282-290. <https://doi.org/10.1080/02791072.2011.628913>

¹⁵⁷ Quijano, A. (2000). Coloniality of power and Eurocentrism in Latin America. *International Sociology, 15*(2), 215-232. <https://journals.sagepub.com/doi/10.1177/0268580900015002005>

¹⁵⁸ Lugones, M. (2007). *Heterosexualism and the colonial/modern gender system*. *Hypatia, 22*(1), 186-219. <http://www.jstor.org/stable/4640051>

of democracy from the Haudenosaunee Confederacy, which included the Mohawk, Oneida, Onondaga, Cayuga, and Seneca nations. Settlers gained control over existing societies by gaining power and control over four spheres:

- Sphere 1: economic control (land)
- Sphere 2: control over authority (military, police)
- Sphere 3: control over gender, family, sexuality
- Sphere 4: control of knowledge

Tlostanova and Mignolo also defined decolonial thinking as breaking free from knowing and being under the colonial matrix of power to unlearn the thinking imposed upon us by education and our cultural and social environments.¹⁵⁹ Decolonial thinking can be accomplished through what Lugones described as “sites of resistance,” which are everyday resistant interactions woven into social life. There are many ways and opportunities for this resistance. Dr. Waubanasum noted that when her children talk about gender in a different way, they resist the colonial gender system and break free from heteronormativity, and this also educates her.

In her study of Indigenous caregiver experiences, Dr. Waubanasum talked to 10 Indigenous relative caregivers across tribes in Minnesota and Wisconsin. In this work, “relative” is defined from a perspective of decolonial thinking; the colonial perspective may define “relative” as a blood relation or kin. Some of the relatives included in Dr. Waubanasum’s study are not taking care of children in their homes but are taking care of their communities. In many Native languages, there is a word or phrase that translates to “we are all related.” Many of the relative caregivers included in the study have dedicated their lives and careers to ensuring that new generations of Native children do not experience what their caregivers have experienced. Several have lived experience with the CWS and foster care system. One is a boarding school survivor. And many are also professionals, activists, and leaders in their communities. In addition to Western research methods, Dr. Waubanasum used Indigenous research methods—including the conversational method—to collect information. At the core of Indigenous research methods, relationality guides the interactions and engagement between researcher and participant. Data analysis was performed using a combination of Indigenous (condensed stories and conversations) and

Western (thematic analysis) techniques. Findings, which Dr. Waubanasum calls “uncovering” or “truth telling” revealed several themes in Indigenous relative caregivers’ responses to the question, “How do you experience the child welfare system?”

The first major theme to emerge from this study was that the CWS perpetuates ongoing colonialism by forcefully removing and separating Indigenous children. A participant named Sage, a young person with an M.S.W., stated:

“I feel like it’s legal kidnapping. CPS has tried to take my daughter away from me, and had I not known my rights, they would have succeeded. I have had several doctors who I asked to look into the conditions that my daughter had that I felt were preventing her from thriving. Instead, the doctors told me that I was an overly concerned first-time mother and not to ‘worry so much.’ Only to find out later that they had called CPS due to the same concerns that I asked them to look into, stating that I was likely not feeding her. Within a couple of months, we fortunately found a doctor of culture, who looked into my concerns, and they were able to get her on the right medications to ensure that she would thrive. It was a fight to keep her out of the system—and one that my own mother lost and her mother lost because not only did they not know their rights, they did not even know that they had rights.”

My mother and I were taken from our homes, our families, and our communities to be raised by people who did not care to try and maintain those connections, nor do I believe they cared about us, as both of us were removed from foster home after foster home following our removal from our birth parents and having most of our relatives severed from our lives prior to adulthood.”

¹⁵⁹ Tlostanova, M. V., & Mignolo, W. (2012). *Learning to unlearn: Decolonial reflections from Eurasia and the Americas*. The Ohio State University Press. <http://hdl.handle.net/1811/51920>

Dr. Waubanasum's study also found that the CWS perpetuates the modern colonial gender system. Kevin, who identifies as a two-spirit gay male, has dedicated his life to protecting children from the CWS through education and advocacy, focusing on the intersection of Native two-spirit LGBTQ+ young people and the CWS. He reported:

"I also speak about the child welfare system failing me because they continued to keep putting me back into a home where more violence was perpetrated upon me. ... At the age of 10, when I was emancipated by the court system, I was forced to go to a boarding school, and my experience in the boarding school was not good. My own social workers, my own child protection program, didn't know how to properly serve me. I was forced to see a psychologist, who was more interested in changing my identity rather than talking about the trauma that I experienced. I don't have really good things to say about the system today."

A third theme to emerge from the study was that the CWS perpetrates colonial violence through negligence, invasion, punishment, and racism. Sage experienced colonial violence through negligence when ICWA noncompliance led to a loss of her identity:

"There are laws in place that should have to make it so it's not like that, and I think about all the stuff that I've missed out on. Even getting back into my culture and getting to know my relatives is hard because I was removed for so long. I realize now that was part of the plan [for removal], not just with me but with Indigenous people all over Turtle Island. I don't want that experience for anyone else because it's incredibly painful. Not only do you lose your relatives, traditions, and connections to your family and community but you lose some of yourself, as well. For a lot of us who were removed, we lose our sense of belonging, which plays a vital role in child development. And I realize now that it was not simply 'lost'; it was stolen, and that is the point."

Lacy, another relative caregiver, experienced colonial violence through invasion:

"I felt invaded at times because the worker had to come to my house and inspect my house. Now the government is involved and can enter my home at will and evaluate us. They had to inspect my house like I was the one who did something wrong. I get it, and I know they have to make sure that a kid is going into a safe house and family, but as a Native person, I have a different feeling about this type of invasion—that feeling that my ancestors had as our lands were invaded. And we still feel like we are being invaded when outsiders come into our homes and they have control over our lives. It's stressful."

A third participant, Susie, talked about colonial violence through punishment in her own avoidance of the CWS. Susie takes care of her nephew so that the system won't criminalize her sister. Ande, a professional with the county CWS, described colonial violence through racism in an encounter with a police officer who told her she had nothing to worry about because she was employed by the CWS. Ande replied, "Let me reiterate: I work for the system. I'm a person of color. I have every reason to be afraid."

A fourth theme identified in Dr. Waubanasum's study was that the CWS is a colonized stressor that triggers historical trauma. Lily, a community leader and advocate, was helping a grandmother navigate the CWS and reported, "When she calls, she gets all kinds of triggered. And by 'triggered,' what I mean is that dealing with the system is a historical trauma trigger because they used words like 'removal' and they used tactics around fear. How are we supposed to engage in healing if we don't ever stop to think about how we're perpetuating these traumas over and over for Native people?"

Study data also revealed that tribal communities perpetuate internalized oppression and colonization. Betty, an elder as well as a social work educator and relative caregiver, reported that she had noticed family distrust in her work. She stated, "The families continue to be distrustful, and they watch the Indian social workers.

If they do something that looks like unfairness, [the families] feel like they're becoming a county worker." When Native people mimic state and county systems, it leads to distrust and more harm and trauma. Kevin also described this when he stated, "So even I believe that our own systems shun two-spirit identity because the identity was lost because of colonization."

The final theme to emerge from the study includes the ways that relative caregivers are delinking from colonial child welfare practices using Indigenous-centered practices and cultural revitalization. Lily described this when she explained:

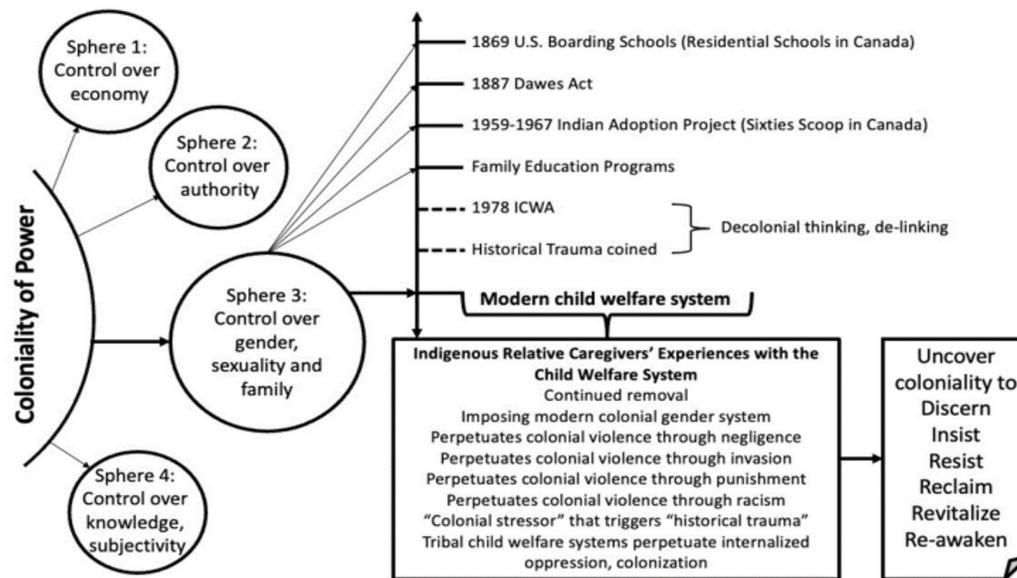
"If we're truly going to look at the current system of child welfare and we're going to say 'Oh, how are we going to apply Indigenous or a Native or Anishinaabe worldview' to how we center around children, then we would put that child center, right? And then by that, we're going to say, 'OK, not only the child [but] the mom and the baby. How would we center them, because they can't exist without each other, right?' So removing babies and children from mothers and then expecting the mothers to get healthy separately is opposite of what we know to be true. We're further disconnecting them [from] the source. So, even thinking in terms of the umbilical cord, that umbilical cord connects them, but in some cases, if it is going to come to an actual removal, then there needs to be some sort of ceremony of passing over guardianship where we are letting the spirits know that 'now I'm the mother.' There should be a better process for that, but there isn't."

Sage talked about decolonization and the abolition of the CWS:

"I feel like if I'm not trying to work myself out of a job, I'm not working ethically. So, yeah, I'm definitely here for abolition of child welfare. We have and have had our own system, not child welfare but our own system. That's what I mean by going back to what we had. We had our own system that I talked about earlier. There was no court. There were no White man's laws. There was community, and there was family, and we were free from colonial violence. Child protection started as a way to assimilate, and it started as a way to kill the Indians [and] save the man. We already kept our kids safe, before settler colonialism; they're not safe now. They're not that safe in the system. Our culture, our language, our concepts of family, our ways of thinking are nowhere to be found in the system. Our system is written by colonizers to maintain control, plain and simple."

Dr. Waubanasum has worked with many tribes across Turtle Island trying to reclaim and revitalize what was stolen from their people. Social work education is riddled with White saviorism, and Dr. Waubanasum is working to counter that with teachings about tribal sovereignty. Researchers need to write about Native populations in terms of tribal sovereign status and the work that Native people are doing in their communities. Dr. Waubanasum challenged workshop attendees to consider how they have been supporting these efforts. The Wahpeton Dakota scholar Waziyatawin, Ph.D., has spoken about the importance of identifying the many ways that colonization has affected Native people, noting that it is first necessary to uncover the way that colonization has seeped into Native people, as much of the time the effects of colonization are subtle and hidden. Resisting, reclaiming, and reawakening are all words used to describe the process of recovering Native culture and identity. A decolonial lens must be applied to clearly see examples of ways that Indigenous people have resisted modern capitalistic ideals that contrast with Indigenous logic and discern what has been imposed

Figure 21. Coloniality in the Child Welfare System



through colonization.^{160, 161} As these are identified, it will be possible to further determine what is needed to reclaim, revitalize, and decolonize Native culture. However, tribes are unique and may be approaching this process in different ways using different terminology, and it is critical to honor the self-determination of each. Figure 21 depicts the process through which colonialism has led to the modern CWS and the experiences of Indigenous relative caregivers with this system, illuminating the need to find and reverse ongoing coloniality of power.

Dr. Waubanasum reported that she is planning two additional publications based on her work with Indigenous relative caregivers. The first will focus on Indigenous kinship and forced reliance on the social welfare systems, and the second will discuss definitions for and descriptions of decolonial child welfare

Session VI Questions

Dr. Jones Harden noted that presenters had been intentionally selected to ensure that attendees would think very carefully about the experiences of different people within the CWS and the many ways in which these experiences may affect the capacity of researchers to conduct research with different populations or even

engage them in this work. HBCD investigators can use the information and messages presented in the workshop to inform research design and interpretation and, in this way, offer a much better reflection of both individual experiences and the outcomes of interest.

(Name not provided) reported that she was particularly interested in the history and experiences of people in the carceral system in the U.S. and how this system is another way that parents are forcibly removed from their children. Most incarcerated individuals are parents of minor children, and 1 in 9 Black children have experienced the forcible removal of a resident parent through incarceration during childhood. Most incarcerated parents are fathers, and only approximately 2% of the children with incarcerated fathers are in the foster care system; however, close to 11% of children with incarcerated mothers are in the foster care system. There is some overlap between the carceral system and the foster care system but less than people might imagine.

- Dr. Dettlaff indicated that he considers the CWS to be part of the broader carceral stage and therefore views the foster care and carceral systems to be the same system. He believes that both systems were designed to maintain the hierarchy that exists in the U.S. today; they may act in different ways to keep Black and brown families down, but the methods of surveillance, regulation, and punishment are used by both.

¹⁶⁰ Cavender Wilson, A. (2004). Reclaiming our humanity: Decolonization and the recovery of Indigenous knowledge. In D. A. Miheesuah & A. Cavender Wilson (Eds.), *Indigenizing the academy: Transforming scholarship and empowering communities* (pp. 69-87). University of Nebraska Press. <https://www.nebraskapress.unl.edu/bison-books/9780803282926>

¹⁶¹ Lugones, M. (2010). Toward a decolonial feminism. *Hypatia*, 25(4), 742-759. <http://www.jstor.org/stable/40928654>

- Dr. Merritt added that researchers should also be mindful of how the educational system plays a role as a pipeline to both the CWS and the carceral system; there is documentation that reports that lead to the involvement of both systems come from the educational system, making it a part of continued surveillance and oversight.

(Name not provided) thanked the presenters and indicated that she had been impressed by the importance of language. She noted that Dr. Merritt had spoken about the importance of precision in language, and she asked Dr. Dettlaff to clarify what is meant by the term “separation” and the range of experiences included in the term “forcible separation.” How can these be better unpacked to reflect the variability in circumstances under which a separation could occur?

- Dr. Dettlaff indicated that he uses the terms “forcible separation,” “involuntary separation,” and “state-sanctioned separation” intentionally, to avoid the use of the word “removal.” “Removal” is intentionally devoid of trauma and gives the impression of something that happens to, rather than something that is imposed on, a family. “Separation” is something that is done to a family.

Dr. Washington spoke with emotion, noting that people do not understand the powerful impact of secondary trauma on her and others. Many people see this information as just numbers when it is not. People are hurt by secondary trauma, including researchers. She noted that she wants people not to waste their time trying to convince others that what is happening is racist but to use their energy and time getting this information out to communities and early social workers. Practitioners and community members are not necessarily reading peer-reviewed articles. If researchers and others want real change, they need to change the audience receiving this information. Dr. Washington further stated that what the panel described is hurtful and is not OK and that no one listening to the panelists in Session VI should be OK after hearing the presentations.

- Dr. Merritt thanked Dr. Washington, noting that she had spoken to colleagues earlier in the week about the fact that although she is a scholar who has benefited from all of the White supremacy aspects of the system in order to be sitting in front of the workshop participants, she is still a Black woman. She added that she needs her White colleagues to

understand that although scientists of color are in the academy, they are part of the communities about which White individuals have developed sometimes erroneous narratives. Interventions and other things are happening in these communities, but researchers of color are still members of these communities and are emotionally invested and affected. Dr. Merritt also indicated that drawing attention to these issues is everyone’s responsibility. Harms are happening, and the fact that scientists of color have achieved success as researchers does not mean that they are not harmed. She reported that she struggled with the presentations on Day 1 because the reality of the experiences of individuals is glossed over when data are presented as prevalence rates and outcomes without context. She stated that it hurts when nobody pays attention to what she and Drs. Dettlaff and Waubanasum have presented.

- Dr. Jones Harden thanked Dr. Washington for being brave enough to share her tears. She noted that the one thing she carries with her at all times is humility and that she and her team defer to research participants. She communicates this deference to research participants to let them know that she is trying to work on her privilege and trying to not be a part of a system that continues to subjugate and oppress them. Dr. Jones Harden emphasized that she feels strongly that if the HBCD Study is going to be carried out in a way that truly includes the populations of parents that are affected by these systems, researchers need to lead by deferring to participant experience and internalizing the messages of traumatic impact that have been shared.
- Dee Bonnick, M.S.W., of the Capacity Building Center for States and Children’s Trust Fund Alliance reported that she was feeling very emotional as an individual with lived experience trying to integrate this experience into the CWS to improve outcomes for children. She described the tension she experiences when thinking about her role and whether her role causes further harm by being part of the problem instead of being part of the solution. This is something she thinks about every day. She also knows that even if she is not part of the system and doing the work that she does, harm is still being done to people in the families that look like her. She suggested that part of the role of individuals with lived experience who do work in these systems

may be to work to dismantle them and replace them with a framework for well-being that supports children and families while maintaining them in their communities. Ms. Bonnick also noted that she wanted to share how emotional she was feeling in response to what had been shared, because she grew up in kinship care and had a child welfare experience as an adult when trying to get help for her son with mental health exceptionalities. There were no resources in her community to support her son, and although they were not separated, the experience with the CWS was traumatic. She stated that she is grateful for the resources and support that happened after the encounter with the CWS but also wants to honor the trauma and pain that remain 20 years after the incident. Part of the reason she does the work she does is out of the hope that other families do not have to have the same traumatic experience that she and others have had.

- Dr. Waubanasum indicated that she wanted to honor the emotions in the room and that researchers do not often experience the expression of vulnerability and emotion in academic settings. She shared that one time when her son was 2 years old, she was crying, and her son told her that it was OK, that tears are good medicine. She reported that in her culture, they believe that their children are from the creator's world, so the creator gave that knowledge and message to her through her son. Dr. Waubanasum also shared that her eldest nephew had just been released from prison, and though it was difficult to leave and travel to the workshop, she was stepping out to call regularly because he was in a vulnerable situation. The first place he went after prison was Dr. Waubanasum's house; like her grandfather, she strives to make her home a safe haven for Native children. Presenting her data at the conference in this context was heavy, and she noted that she appreciated the emotions being shared, because they were helping her to connect with other attendees and express her own feelings.
- Dr. Dettlaff acknowledged that part of the reason these topics bring up so much emotion for panelists and workshop attendees is that it is a struggle to

disseminate this information to the extent that it becomes common knowledge. He stated that as he and other panelists were presenting, there was an active group of child welfare researchers in the field writing papers to try to convince readers that racism is not a problem in the CWS. Dr. Dettlaff indicated that these types of researchers run statistical models and report that results do not reflect disparities. He noted that Americans need to reject the notion that the CWS is exempt from the racism that clearly exists in the rest of American society. Studying the disparities in the system and learning about the disparities in the system is as traumatic as it is because the field has not yet arrived at a place where racism is acknowledged as an ordinary, everyday experience in the CWS on a consistent basis.

- Dr. Merritt reiterated that this lack of agreement and acknowledgment is very harmful and is very upsetting to her on a consistent basis. Sharing the narratives and lived experiences of how her community must navigate the world is critical; researchers and others know academically that there is a problem but do not actually digest on a deeper level how this problem is individually experienced. She noted that she could share many stories that would have everyone in tears all day long. It is difficult to share these as a person of color in a racist system, where people of color are likely to be dismissed.

Dr. Jones Harden thanked the panel for pushing researchers and workshop attendees in this area and advised participants to take the presentations of the panel and the issue of racism and disparities in the CWS seriously. This is critical for the HBCD Study but also for all areas of science, and if researchers are serious about bringing the voices of people with lived experience into the work, researchers must internalize these messages. She also advised participants to consider how, if this is happening to “privileged” individuals with Ph.D.s, it is affecting the families being studied. Half of the HBCD sample must come from high-risk backgrounds, and investigators need to consider what these individuals have experienced.

Session VII: Developmental Research and Child Welfare

(Julie Poehlmann, Ph.D., University of Wisconsin–Madison; Darcey Merritt, Ph.D., University of Chicago; Lonnie Berger, Ph.D., University of Wisconsin–Madison; Haksoon Ahn, Ph.D., University of Maryland; Dee Bonnick, M.S.W., Children’s Trust Fund Alliance)

Dr. Poehlmann noted that workshop attendees had heard a great deal of important information that had truly moved them and that it would be important for attendees to carry this forward into their work. Moving forward, researchers should consider how to deeply listen to and honor the voices of participants in research who have lived experience. She noted that for 25 years, she has studied children with a parent involved in the justice system and that nearly everything she has learned has come from individuals with lived experience. Her job is to amplify their voices and educate people about these individuals’ strengths and struggles and ways in which the system has failed them. She encouraged all workshop attendees doing work in this area to ensure that they are amplifying the voices of those who have been affected by the CWS, deeply listening to those with lived experience, and educating others about what is learned in the process.

Dr. Poehlmann also briefly introduced the four Session VII panelists: Dr. Merritt, presenting more of her work that centers on the lived experiences of families who have been affected by the CWS; Dr. Berger, who is Associate Vice Chancellor for Research in the Social Sciences and Vilas Distinguished Achievement Professor in the Sandra Rosenbaum School of Social Work at the University of Wisconsin–Madison and has done extensive research with the goal of informing public policy, helping families access resources, and promoting positive child development; Dr. Ahn, who is an Associate Professor in the School of Social Work at the University of Maryland and has conducted a statewide evaluation of child welfare services and policies in Maryland; and Ms. Bonnick, who is a National Parent Consultant for the Children’s Trust Fund Alliance (CTFA) and recipient of the NYU Silver School of Social Work’s Social Justice Award and works to transform the front end of the CWS.

Acknowledging Racism, Racialized Poverty Surveillance, and the Impact on Family Well-Being (Darcey Merritt)

Dr. Merritt began by reminding participants that no one intends to experience poverty and racism and that the consequences of these experiences should not be blamed on parents who are only trying to raise their families to

the best extent of their abilities and resources. Parental behaviors and the intention of these behaviors should be considered a function of available resources and histories of structural discrimination in their environmental contexts. Dr. Merritt believes that behaviors of parents related to poverty and oppression should not be deemed maltreatment and that there is a need for uncompromising policy revisions to mandate a nonjudgmental approach, from initial contact through the course of involvement with the CWS. Racial bias awareness during screening of reports is imperative and should always include ways in which individuals are held accountable for failing to constantly assess how their biases are affecting decisions made about the lives of children and parents, including decisions to place them under CWS oversight. With her work, Dr. Merritt suggests a renewed effort to support and empower parents and decrease punitive oversight.

Poverty, particularly extreme poverty, is a form of trauma that results in a host of deleterious outcomes, such as poor functioning and suboptimal behavioral choices. Risk factors that result in increased CWS oversight are generally outside of the control of parents, primarily because of their positionality in society. This results in higher likelihood of CWS involvement and surveillance. Significant research documents the relationship between poverty and maltreatment, but far less research exists that has considered the impact of racialized poverty, which is different. Dr. Merritt has documented many qualitative accounts of the lived experiences of Black families that have perceived racial biases in their interactions with CWS professionals, and parents in these families have overwhelmingly reported feeling judged, disrespected, and often misunderstood. Some examples of these accounts are provided below.

“I don’t know. I don’t know. I just think if you’re a minority and you have an ACS case, they have a certain perception of you. It’s like a stereotype. ... If you already have an ACS case, they think in their mind, ‘Y’all are the worst type of parent.’”
— Bianca (name changed), 28 years old, Latina, has one child (male, 10 years old)

"Nope. They don't give a damn. ... Skin means a whole lot. If I was light enough, if I was white enough, bright enough ... they'd be a little nicer to me. ... Because I'm dark, the word was said [that I] look aggressive. This is how I talk. I am calm. This is how I talk. ... But this comes across as aggressive."
— *Olivia (name changed), 35 years old, African American, has six children (ages 9 to 27; the older children are the biological children of Olivia's husband, who is older than she is)*

Olivia's statement also speaks to colorism, where stereotypes and judgments are based not only on race but also on skin tone within race.

Neglect cannot be disentangled from race and poverty. Researchers need to consider the intersection of these populations of color and those with low socioeconomic status and ways that this results in oversurveillance, including biased judgments regarding child maltreatment risk. This intersection can be understood as racialized poverty in the U.S., particularly associated with Black/African American families involuntarily living in poverty and suffering systemic and generational oppression based on the skin they live in. Experiences with poverty are intensified by structural racism in policy and practice, including mandated reporting from school professionals and others. Most reports to CWS come from professionals in medical and school settings and law enforcement, and it is important to consider how individuals are coming under the watchful eye of people who are then mandated to cause trauma. Mandatory reporting laws mandate that trauma be caused, because they mandate that even unintentional neglect be reported to the CWS. There is a need for more research and scholarship examining how surveillance affects lived experiences of individuals living with racialized poverty. Racialized poverty shapes perceptions of individuals and families, and these perceptions are embedded in all institutional procedures and policies that are responsible for protecting children.

Abuse and neglect differ in all ways, including with respect to race, caste, and class. Dr. Merritt advised workshop attendees to consider what is meant by "minimally adequate care" and who is allowed to define what constitutes minimally adequate care. The CWS was never intended to address poverty, and it is time to think about interventions that address the harm caused by physical abuse and not unintentional neglect. Dr. Merritt noted that most parents want to take care of their children and provide for them, and she presented the following passage from an interview with Carla (name changed):

"I don't worry about being a parent. Like, my biggest worry if I did worry it would be, like, just to be able to provide, basically— just providing for them, giving them what they deserve ... because I live in a low-income neighborhood where I feel like all the children ... I mean, I'm not singling out one child, but I just feel like the children have issues because they don't have the necessities or sometimes they don't have the things that they need or maybe want. ... I just feel like if I had given myself the chance to further my education, then I think that I could probably provide more or do more for them, definitely."
— *Carla, 33 years old, African American, has one child (female, age 7)*

Dr. Merritt reminded workshop participants that these narratives matter and that poor Black children and their parents matter. Numbers and data are science, but so are lived experiences, and quantitative data needs to be accompanied by qualitative accounts to provide a comprehensive picture. It is also important to consider poverty as a function of racism for some population groups and understand that this affects risk factors, protective factors, and trends in CWS reporting. Many Black children are poor; considering the etiology of this fact and the reasons some population groups are plagued by injustices is a necessary first step in moving toward a solution.

Dr. Merritt's work examines the impact of the CWS on parents, and a salient impact she has identified in her research is a lack of dignity, exemplified by the following statements by participants in Dr. Merritt's studies:

"We were supposed to get a washer and dryer, because like I said, we are a Title I school, and for the community, in case they don't have enough, they could come to the school and wash their clothes. I'm telling you, it's very, very sad." — Mom 3

"So she would come ... and say, 'Oh, you don't have enough food.' And you might not see food in my fridge, but I have food in my freezer. And that's because I can't afford to buy fresh food ... every few days, right? I don't have the luxury of time or resources to do that. So I'm going to buy frozen foods because I know they last longer, and I can cook them whenever I need." — Mom 7

"Because I wasn't showing ... I was able to donate blood without them knowing that I was pregnant and to pay for rooms when we couldn't. ... Because of that, they said that I was using needles. I've never used a needle in my life. ... They didn't believe that I was going to the blood bank. ... Never checked, never followed on anything ... never drug tested us, nothing." — Mom 8

Other participants commented on the power dynamics and inequities they experienced when dealing with the CWS:

"But you know what makes me upset? If your child is in foster care, they get everything. ... My daughter couldn't get mental services because she wasn't in the foster care system. That is bogus, outrageous, and not correct. How dare you say I have to give up my rights for her to get care and help? What kind of injustice is that? Even when Christmastime comes ... they only have gift cards now for the kids that are in foster care. ... What about the struggling parents that still have parental guardianship and rights over their kids? That's wrong." — Mom 10

"I felt like they were trying to set me up for something bad to happen so they can take both of them and I could go to jail. But I wasn't letting them do that. I wasn't giving them that victory, satisfaction of doing that. I'm like, 'I'm above y'all. I already know how y'all work. I've been in foster care, too. Let's not get it twisted. I know how you all work.'" — Mom 14

Dr. Merritt described some of the fears experienced by Black individuals living in the United States today, including:

- Driving while Black
- Breathing while Black
- Running while Black
- Knocking on the wrong door while Black
- Bird-watching while Black
- Shopping while Black
- Sleeping while Black
- Living while Black
- Parenting while Black

Dr. Merritt posed the question of whether living while Black is a risk factor for being affected by the CWS.

Child removal is traumatic for children and parents. One study participant described her state of mind as a result of CWS involvement:

"Oh, no, they're going to take the kids, all the kids. I'm going to lose my kids again. This can't be happening to me again. ... I felt like they just made up their mind without trying to figure out how to help me and my family and my kids stay together."

Another parent described her experience of forcible removal, reporting, "*They took them right away, the day they came to my house to do their investigation with the police. ... They took my kids, that day.*"

Dr. Merritt questioned the intent of the CWS, asking whether the goal is to save children of color from poverty or blame parents of color for being poor. She noted that in her opinion, the system is doing what it was designed to do. All of these qualitative accounts of experiences provide a clear argument for the importance of including specific lived experiences in research on the CWS. Societal and individual histories and lived experiences should be centered by all who are remotely concerned about the well-being of disenfranchised (i.e., vulnerable because of harm) children, their parents, and their families. Dr. Merritt closed with a reminder that poor Black and brown mothers love their children and that fathers are important, as well.

The 'Effects' of Foster Care on Development and Well-Being: What Do We Know? (Lonnie Berger)

Dr. Berger opened his presentation by stating how moved he felt as a workshop attendee, both intellectually and emotionally. He noted that the workshop had been an incredibly touching and thought-provoking conversation of which he was grateful to be a part. He echoed the importance of both qualitative and quantitative data, pointing out that there are different types of research questions and different types of evidence and that all need to be part of the conversation and research. Lived experiences and quantitative probabilities are complements to each other, not substitutes for each other, and they need to be brought together to get policies and practices right.

Dr. Berger indicated that he would be addressing a very specific set of quantitative questions in his presentation, looking at the literature on how entry into foster care affects children's developmental trajectories in a particular set of domains of life outcomes. He emphasized that the content of his presentation and research focus do not deny the pervasiveness of racism throughout U.S. society, of which the CWS is one microcosm. Instead, his content and data should be viewed within the context of the racism, inequities, and other issues inherent in the CWS and in broader society. He noted that his slides included the term "CWS-involved," rather than "CWS-impacted," because they were submitted prior to the workshop discussion about language.

The core question Dr. Berger's presentation was intended to address is whether CWS involvement, out-of-home placement (OOHP), and/or aging out of care cause adverse life outcomes. Well-established research evidence indicates

that youths who experience CWS involvement, OOHP, and/or aging out of care disproportionately experience adverse outcomes in almost all domains throughout the life course, including socio-emotional, lifetime earnings, education, and probability of being incarcerated. Significant heterogeneity exists in this research, and outcomes differ by experience prior to, during, and after foster care. There are also potential differences according to risk and resiliency factors, and outcomes also differ in relation to the timing/developmental stage of experiences. Much of this heterogeneity and the impact on outcomes have not been unpacked. If it is the case that poor outcomes are being driven by other risk factors, including having experienced maltreatment prior to CWS involvement, then poor outcomes may be demonstrating that CWS involvement does not compensate for preexisting disadvantages, and policy and practice should target these preexisting factors. If, however, poor outcomes are caused by CWS involvement, then CWS involvement should be the target of intervention and changes to policy and practice. It is also possible that both CWS involvement and other risk factors are the cause of poor outcomes. Consideration of whether CWS involvement is a marker for children already on a bad trajectory or the cause of the bad trajectory is critical in the design of approaches for improving the system and the lives of people involved. Counterfactuals are important.

Three types of studies have been used in attempts to address questions of causality in this area. Between-group analyses have compared CWS-involved children with children without CWS involvement, children who were not removed from the home with those who were, and children who did not age out of care with those who did—attempting to control for as many background characteristics as can be observed. These studies have revealed very large disparities between groups in life outcomes, suggesting strong associations between CWS involvement and poor outcomes.^{162, 163, 164} Notably, there are limits to background characteristics that can be observed in any kind of quantitative data, including

¹⁶² Courtney, M. E., Okpych, N. J., Charles, P., Mikell, D., Stevenson, B., Park, K., Kindle, B., Harty, J., & Feng, H. (2016). *Findings from the California Youth Transitions to Adulthood Study (CalYOUTH): Conditions of youth at age 19* (ED614175). ERIC. https://www.chapinhall.org/wp-content/uploads/CY_YT_RE0516.pdf

¹⁶³ Doyle, J. J., Jr., & Aizer, A. (2018). Economics of child protection: Maltreatment, foster care, and intimate partner violence. *Annual Review of Economics*, 10, 87-108. <https://doi.org/10.1146/annurev-economics-080217-053237>

¹⁶⁴ Naccarato, T., Brophy, M., & Courtney, M. E. (2010). Employment outcomes of foster youth: The results from the Midwest Evaluation of the Adult Functioning of Foster Youth. *Child and Youth Services Review*, 32(4), 551-559. <https://doi.org/10.1016/j.childyouth.2009.11.009>

data from propensity score matching studies, and in this research it is not possible to observe the extent to which participants have experienced a range of adverse childhood experiences (ACEs), the degree to which they have experienced maltreatment, or the ways that experiences have been internalized. It is likely that between-group results are biased by unobserved (selection) factors.

Researchers have also conducted within-group and within-individual analyses, comparing changes in socio-emotional and cognitive assessments before and after CWS involvement/OOHP. The use of baseline (before) data in these studies is intended to account for the effect of all prior experiences and background characteristics on assessments. These studies tend to indicate very little to no effects of OOHP on the outcome measures used, suggesting that children's functioning in measured domains is approximately the same prior to and after foster care.¹⁶⁵ A significant limitation to these studies is the paucity of data that can be used to perform these analyses; the National Survey of Child and Adolescent Well-Being (NSCAW) is the data source that has been used the most. These analyses also cannot be used to examine binary categorical outcomes that occur only once, such as a teen birth or graduation from high school.

The third and arguably most rigorous way to detect a causal effect of CWS involvement has involved natural experiments. These studies have taken advantage of the fact that children entering the CWS are randomly assigned to child welfare workers who have different propensities for removing children from their homes, and these studies have included that random variation in propensities in analyses to examine the likelihood that a child's outcomes would have been different if the child had been assigned to a different child welfare worker. Results of these studies have been mixed. Some well-known studies using data from Illinois in the 1990s have suggested that if children were assigned to caseworkers with very high removal rates, the children were more likely to experience significantly poorer outcomes in areas such as employment, criminal justice involvement, and teen pregnancy.^{166, 167} More recent studies using

data from Rhode Island and Michigan have generated mixed findings. Anthony Bald and colleagues (2022), using Rhode Island data, found that girls removed from the home at a young age function better in school, have better test scores, and are less likely to repeat grades; however, this did not hold true for boys or children removed at older ages.¹⁶⁸ Studies by Max Gross and E. Jason Baron (2022)^{169, 170} suggested improvements in arrest, incarceration, and conviction outcomes and some educational attainment outcomes in children removed from the home. All estimates in these studies apply only to marginal children who would have been removed by one worker but not by the other. These are likely to be children who experienced the least severe abuse or neglect. Although the approach applied in these natural experiment studies is more rigorous in elucidating cause-and-effect relationships, the results are not generalizable. To truly examine the impact of child welfare removal on later outcomes, it is necessary to study the children who would have been removed regardless of worker assignment.

It is difficult to obtain good child welfare data that include observation of children prior to, during, and after foster care; large samples of children in the CWS; and children not involved with the CWS. In Wisconsin, the Institute for Research on Poverty (IRP) works closely with state agencies and is able to house and harmonize all state social welfare program data. Many of these data sets include data from as early as the 1990s. The longitudinal linked administrative data from the Wisconsin Administrative Data Core, housed at IRP, include data from the entire population of children who are involved with the CWS and children receiving any type of cash benefit, such as temporary assistance for needy families or supplemental security income (SSI) benefits. The data set includes information on parental earnings; in-kind assistance, including Medicaid health records since 2009; child support payments; public school records; and records of parental incarceration. It also provides a comprehensive sample for examining outcomes that are measured in administrative data.

¹⁶⁵ Berger, L. M., Bruch, S. K., Johnson, E. I., James, S., & Rubin, D. (2009). Estimating the "impact" of out-of-home placement on child well-being: Approaching the problem of selection bias. *Child Development*, 80(6), 1856-1876. <https://doi.org/10.1111/j.1467-8624.2009.01372.x>

¹⁶⁶ Doyle, J. J., Jr. (2007). Child protection and child outcomes: Measuring the effects of foster care. *American Economic Review*, 97(5), 1583-1610. <https://doi.org/10.1257/aer.97.5.1583>

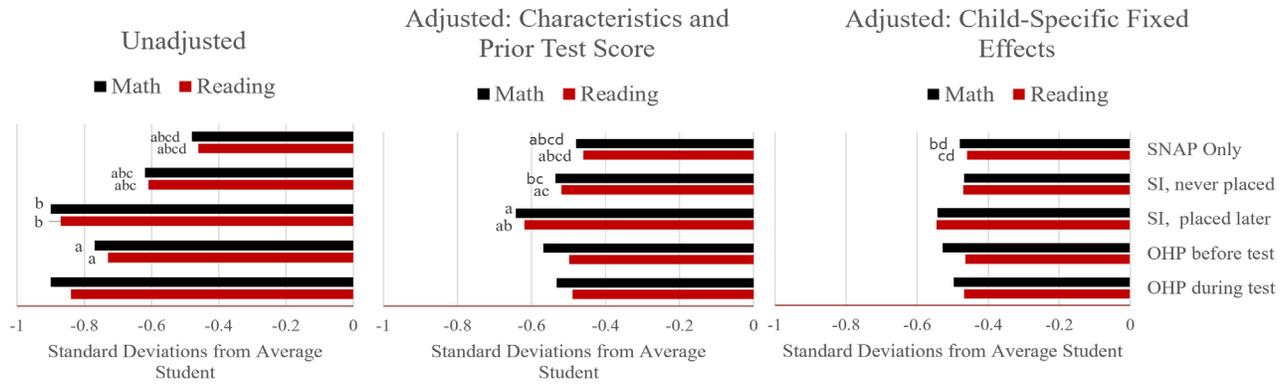
¹⁶⁷ Doyle, J. J., Jr. (2008). Child protection and adult crime: Using investigator assignment to estimate causal effects. *Journal of Political Economy*, 116(4), 746-770. <https://dx.doi.org/10.1086/590216>

¹⁶⁸ Bald, A., Doyle, J. J., Jr., Gross, M., & Jacob, B. A. (2022). Economics of Foster Care. *J Econ Perspect*. 2022;36(2): 223-246.

¹⁶⁹ Baron, E. J., & Gross, M. Is there a foster care-to-prison pipeline? Evidence from quasi-randomly assigned investigators. Unpublished.

¹⁷⁰ Gross, M., & Baron, E. J. (2022). Temporary stays and persistent gains: The causal effects of foster care. *American Economic Journal: Applied Economics*, 14(2), 170-199. <https://doi.org/10.1257/app.20200204>

Figure 22. Standardized Test Scores by CPS/OHP status



^a Differs from OHP during test at $p < .05$.
^b Differs from OHP before test at $p < .05$.
^c Differs from SI placed OH later at $p < .05$.
^d Differs from SI, never placed at $p < .05$.

Using annual standardized tests to assess school achievement in children over time, Dr. Berger’s research team compared five groups of public school students (Figure 22):¹⁷¹ children with no CWS involvement who, at the time of the test, were receiving Supplemental Nutrition Assistance Program (SNAP) benefits; children who had experienced CWS investigations but were not removed from the home; children who were investigated and had not been removed at the time of the test but were removed at a later date; children who had been placed out of the home in the past but were back at home at the time of the test; and children in OOHPs (labeled OHPs in Figure 22). In each chart in Figure 22, the average test score for children in Wisconsin who were not part of any of the five groups is represented by zero. Unadjusted test scores for children receiving Temporary Assistance for Needy Families (TANF), indicated by the top two lines in the chart on the left, were approximately 0.5 standard deviation (SD) lower than the Wisconsin average. Unadjusted test scores for children in OOHP at the time of the test, represented by the bottom two lines in the chart on the left, were approximately 0.85 SD below average. This illustrates the significant difference between these groups, although approximately 75% of CWS-involved children were receiving TANF before becoming CWS-impacted, suggesting that 50% to 60% of the gap between both groups and the average Wisconsin student could represent economic disadvantage. Also notable are the results for children who had been screened but would be removed

later, indicated by the middle two lines and representing the lowest test scores among the groups. In the middle chart, results have been adjusted by prior year test scores to control for background characteristics. These results indicate that most CWS-involved groups still differ from children receiving TANF with no CWS involvement; however children placed in foster care before and after test administration appear to have performed better on standardized testing than children who had experienced CWS involvement but no removal from the home. The third chart presents within-child data for children in the same categories. The results of this analysis suggest that there was very little difference between children in OOHP during testing and children who had been placed in OOHP before but had returned to the home by the time of the test. Results also suggest that children in OOHP during the test performed slightly worse than children receiving TANF only, and children who had been screened into the CWS and placed later performed significantly worse than TANF-only children. Taken together, results indicate that test scores were lowest for children with CWS involvement who had not been removed from the home at the time of the test but were removed at a later date and that children who enter foster care are at high risk of having test scores below average, but entry into foster care does not appear to significantly worsen test scores.

Other research has demonstrated very high rates of teen motherhood among children who become CWS-involved; however, the likelihood of becoming pregnant is highest during the period before CWS involvement. This likelihood decreases with CPS investigation and

¹⁷¹ Berger, L. M., Cancian, M., Han, E., Noyes, J., & Rios-Salas, V. (2015). Children’s academic achievement and foster care. *Pediatrics*, 135(1), e109-e116. <https://doi.org/10.1542/peds.2014-2448>

decreases significantly more with placement in foster care. The likelihood of becoming pregnant increases slightly after reunification but does not return to the original level of risk.¹⁷² In the educational attainment domain, longer duration of foster care is associated with higher rates of high school graduation and college enrollment. These rates are still significantly lower than those of average children; however, it does not appear that foster care is significantly worsening this trajectory. Children who age out of foster care also tend to graduate high school and enroll in college at higher rates than children who are reunified with their families. Longer duration of care is also associated with greater earnings than shorter duration of care, and youths who age out of foster care have very similar earnings in their mid-20s to those of youths who are reunified with their families.¹⁷³ These youths who age out of foster care are substantially less likely to be incarcerated than those who reunify with their families, and this difference is especially pronounced for Black youths.¹⁷⁴

When considered together, all of the findings presented appear to indicate that all CWS-involved youths—including those in OOHP or aging out of care—are at greater risk of poorer educational, social, and economic outcomes than non-disadvantaged youths. They are also at greater risk than disadvantaged youths without CWS involvement, although the difference between these groups is less pronounced. CWS involvement, OOHP, and aging out of the foster care system do not appear to cause poor outcomes in certain domains and may even lead to some improvements, but effects in other domains have not been rigorously examined and are not known. Findings do not imply that CWS involvement, OOHP, and aging out of care are not disruptive, stressful, or traumatic for youths and families or that interactions with the CWS are not adverse experiences for these families. It is possible that policy and practice may overemphasize individuals experiencing CWS involvement, OOHP, and aging out of care, given that the larger populations at risk of these experiences are already at substantial risk of adverse developmental outcomes and that these experiences do not appear to exacerbate poor developmental trajectories.

¹⁷² Font, S. A., Cancian, M., & Berger, L. M. (2019). Prevalence and risk factors for early motherhood among low-income, maltreated, and foster youth. *Demography*, 56(1), 261-284. <https://doi.org/10.1007/s13524-018-0744-x>

¹⁷³ Font, S. A., Berger, L. M., Cancian, M., & Noyes, J. L. (2018). Permanency and the Educational and Economic Attainment of Former Foster Children in Early Adulthood. *American Sociological Review*, 83(4), 716-743. <https://doi.org/10.1177/0003122418781791>

¹⁷⁴ Font S, Berger LM, Slepicka J, Cancian M. Foster Care, Permanency, and Risk of Prison Entry. *Journal of Research in Crime & Delinquency*. 2021; 58(6):710-754. doi:10.1177/00224278211001566

Many interventions, especially those focused on well-being, target only youths and families involved with the CWS, particularly those experiencing OOHP or aging out of foster care; however, all youths and families at risk of CWS involvement might benefit from educational, mental health, general health, and economic supports. Youths who age out of care receive considerably more supports than those who exit care through reunification; the latter group receives few ongoing services. All youths exiting care might benefit from similar interventions.

Child Welfare Services and Outcomes: Impact of Family Engagement (Haksoon Ahn)

Dr. Ahn noted that she was grateful to be a part of such a powerful workshop. She also noted that she had not had time to update the presentation since the discussion on language.

Dr. Ahn has conducted research on the evolution of child welfare policy and practice in Maryland, with a focus on the impact of family engagement and ways to utilize findings to inform policy and practice. She provided a brief overview of child welfare statistics in Maryland in relation to the United States overall (Figure 23),¹⁷⁵ noting that sexual abuse accounts for nearly 33% of maltreatment in Maryland, compared with just over 10% nationally. When these data are examined in relation to data collected prior to the COVID-19 pandemic, it is apparent that this percentage has increased in Maryland; however, this is because the total number of reported cases of maltreatment has decreased since the beginning of the pandemic, while the number of reported cases of sexual abuse has remained approximately the same.

There is considerable disproportionality in the Maryland child welfare population: African American children represent 31% of the total population of children in Maryland but make up 52% of the total Maryland child welfare population (Figure 24).¹⁷⁶ Since the Children's Bureau established a process for monitoring state child welfare programs in 2000, Maryland has conducted three rounds of child and family services review (CFSR). The third round was conducted by a partnership including the University of Maryland, the Children's Bureau, the

¹⁷⁵ United States Department of Health and Human Services. Child Maltreatment Report 2021. 2023. <https://www.acf.hhs.gov/sites/default/files/documents/cb/cm2021.pdf>

¹⁷⁶ Source: <https://www.childtrends.org/publications/state-level-data-for-understanding-child-welfare-in-the-united-states>

Figure 23. Child Maltreatment in Federal Fiscal Year 2021 in Maryland Relative to the United States

United States	Maryland
<ul style="list-style-type: none"> • 40.7 children per 1,000 received either an investigative response or alternative response • 19.5% of children investigated were victims of abuse or neglect • 8.1 victim children per 1,000 children • Maltreatment type: <ul style="list-style-type: none"> – Physical abuse: 16% – Neglect: 76% – Sexual abuse: 10.1% 	<ul style="list-style-type: none"> • 15.7 children per 1,000 received either an investigative response or alternative response • 24% of children investigated were victims of abuse or neglect • 4.6 victim children per 1,000 children • Maltreatment type: <ul style="list-style-type: none"> – Physical abuse: 18.9% – Neglect: 56.7% – Sexual abuse: 32.8%

Maryland Department of Human Services, and local departments of social services (LDSS). This ongoing approach has created a unique opportunity to incorporate voices from CWS frontline workers, families and youths, and professionals involved in child welfare cases, allowing a more comprehensive understanding of cases and review of outcomes. The process includes interviews with everyone involved in a child welfare case, which can range from parents and other relatives to educational professionals and medical professionals. Sometimes when the CFSR team contacts these individuals, they are concerned that there is a problem with their case, and workers explain that cases are identified in administrative data through random selection to provide information that will be used to inform policy and practice. After interviews are conducted and findings are analyzed, the research team creates a report of findings to communicate strengths, areas in need of improvement, and suggestions for improving the process for working with families and

children to the local department of social services. The CFSR team remains in contact with LDSS to provide technical assistance and share ways that agencies’ practices are affecting outcomes according to the data.

The CFSR examines seven outcomes in three domains—safety, permanency, and well-being—using hundreds of indicators. The safety-related outcomes are:

- Outcome 1: Children are, first and foremost, protected from abuse and neglect.
- Outcome 2: Children are safely maintained in their homes whenever possible and appropriate.

The permanency-related outcomes are:

- Outcome 1: Children have permanency and stability in their living situations.
- Outcome 2: The continuity of family relationships and connections is preserved for children.

Figure 24. 2020 Demographics of Maltreated Children in Maryland

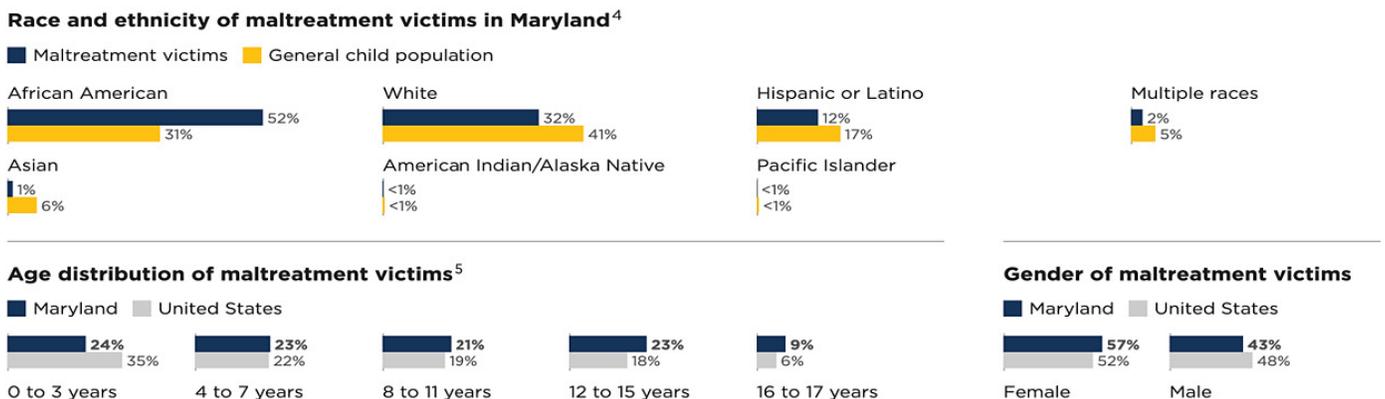
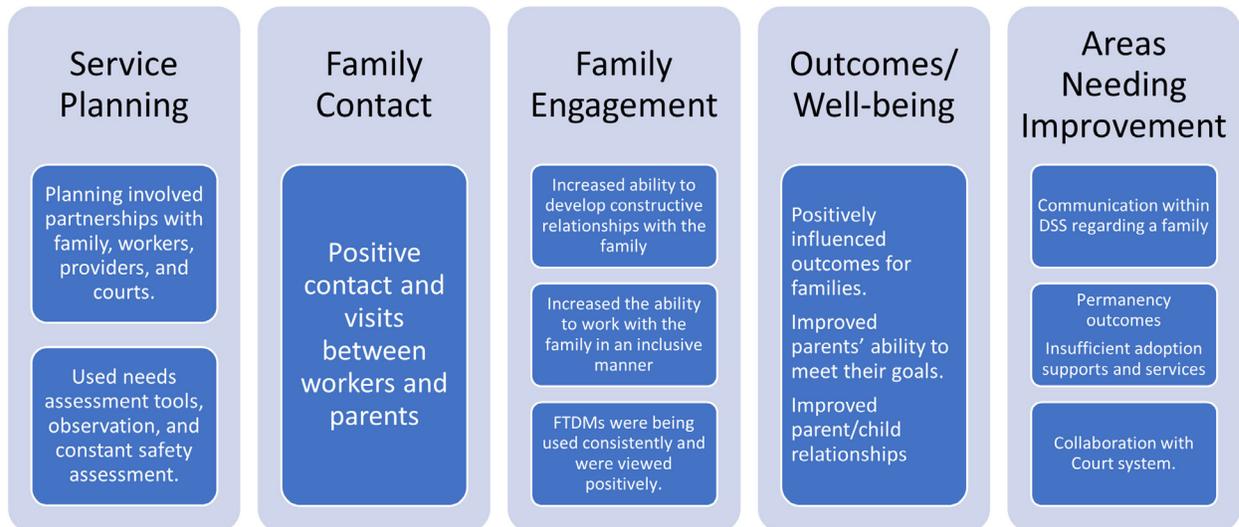


Figure 25. Maryland Round 3 CFSR Results



The well-being-related outcomes are:

- Outcome 1: Families have enhanced capacity to provide for their children's needs.
- Outcome 2: Children receive appropriate services to meet their educational needs.
- Outcome 3: Children receive adequate services to meet their physical and mental health needs.

Other quantitative data used in the review process include the CFSR's seven systemic factors, as well as information gathered from the Maryland Child, Juvenile, and Adult Management System (CJAMS). The process also incorporates qualitative data to provide context and insight for quantitative data, as well as a method to integrate family voices. Reviewers conduct focus groups twice per year statewide, review case records, and conduct on-site case-related individual interviews with family members, foster parents, workers, supervisors, professionals, and other individuals involved in cases.

Results from the third round of CFSR are listed in Figure 25. Throughout the entire time period that a child is involved in the CWS, family engagement was identified as being critical to improving the child's safety, permanency, and well-being. At the same time, family engagement was identified as an area in need of improvement, in terms of number of visits and quality of visits. Specifically, the CFSR found that there was a lack of consistent high-quality engagement with parents, including fathers, and there were challenges in communicating with incarcerated parents and parents who did not speak English. Visit quality is determined

based on whether families can talk about their needs and struggles, as well as on the kinds of conversations families have with workers about providing better services to meet family and child needs. In the third round, the Maryland CFSR identified support for family needs as another area in need of improvement and determined that children and families were experiencing inconsistent provision of services. Among cases reviewed to determine whether provision of services to children was an area in need of improvement or a strength for CWS, 71% (n=4,051) were rated as strengths; however, only 40% (n=3,508) of cases ratable for provision of services to parents were rated as a strength.^{177, 178} Although some CWS workers have asked why, in cases of child removal, they should be working with parents—including attempting to contact a biological parent outside of the household if necessary, working with the entire family, and including any children remaining in the home—this is essential to the safety, permanency, and well-being of the child. Workers should make concerted efforts to work to support a relationship between the child and both parents, including any parent who is not involved in their child's life.

Given the importance of family engagement, Dr. Ahn has worked to identify ways to incorporate engagement into research and recommendations. She has examined family engagement through family team decision-making (FTDM) meetings, implemented statewide in 2012. These

¹⁷⁷ Ahn, H., DeLisle, D., & Conway, D. (2021). Child and family services review (CFSR) and child welfare outcomes in the United States. *Journal of Public Child Welfare*, 16(5), 679-703. <https://doi.org/10.1080/15548732.2021.1957067>
¹⁷⁸ Ahn, H., DeLisle, D., & Conway, D. (2021). Child and family services review (CFSR) and child welfare outcomes in the United States. *Journal of Public Child Welfare*, 16(5), 679-703. <https://doi.org/10.1080/15548732.2021.1957067>

meetings apply a family-centered practice model to engage families whose children are engaged in the CWS. In an FTDM meeting, a trained professional facilitator serves as a neutral third party not previously involved with the case to create a safe space for family members, youths, caseworkers, supervisors, and other professionals (e.g., attorneys, mental health providers, and educators). The facilitator facilitates a discussion about the case goal among the individuals involved and helps to determine the next steps that are in the best interest of the child. Dr. Ahn has observed many cases in which children have been diverted in lieu of removal because of this type of meeting. An FTDM meeting is held at a time of important case events, including removal, planned removal, considered removal, placement changes, permanency plan changes, and youth transitions. If the meeting is not held at the time of removal, caseworkers are expected to hold an FTDM meeting within six weeks of removal and to document the meeting in administrative data.

Previous research supports the importance of ongoing parental engagement in case planning and reunification services through the use of team meetings¹⁷⁹ and indicates that participant engagement in FTDM is a significant service planning predictor for the achievement of family goals and the protection of children's safety.¹⁸⁰ To examine the impact of family engagement on service, permanency, and reentry outcomes, Dr. Ahn used multiple data sources:

- Quantitative sources
 - Administrative data from CJAMS
 - Worker's Attitude and Practice Survey
 - The FTDM Feedback Survey (family members, youths, workers, supervisors, and other professionals)
 - LDSS's self-reported FTDM data
- Qualitative sources
 - Integrated Practice Model–related focus groups
 - On-site case-related individual interviews with family members, foster parents, workers, supervisors, and other professionals

Because Maryland does not have a comprehensive linked data system like the IRP in Wisconsin, Dr. Ahn conducted her own statewide survey to collect feedback from

individuals involved with the CWS (the FTDM Feedback Survey). Analysis of all data from qualitative and quantitative sources revealed disparities in the CWS by race, as well as by income.¹⁸¹ White family members were more likely to be offered supportive services, especially financial services. This finding is in stark contrast to a second finding indicating that most of the families below the poverty line or in more need of financial support were African American and were not offered financial services. Surveyed individuals below the poverty line were also less likely to be offered services in these categories: employment services, mental and physical health services, education and social support services, and any type of services overall.

Dr. Ahn also utilized administrative data to conduct the first study to examine associations between family engagement and reunification in Maryland. According to administrative data,¹⁸² among children in foster care in fiscal years 2015–2018, 55% had a case plan goal of reunification with a parent or primary caregiver; however, only 47% of children with a goal of reunification achieved reunification with a parent or primary caregiver. Using data from CJAMS on 1,134 Maryland children placed in foster care between January 1, 2017, and December 31, 2017, and tracked until November 30, 2022, Dr. Ahn determined that 64.7% of children in this sample with a goal of reunification achieved reunification.¹⁸³ Sample characteristics are presented in Figure 26. Among children in the sample who were removed from the home, removal FTDM meetings were held for only 46.05%; 22.45% received other types of FTDM, including meetings on placement or permanency change. All children removed from the home, whether the removal is an emergency or a planned removal, are expected to be provided with an FTDM meeting; however, 31.5% of children removed were not provided with any type of FTDM. Local agency workers indicated that meetings were scheduled but parents did not show up or left before the end of the meeting and there was insufficient time to reschedule. Many workers stated that their caseload was too high to be able to dedicate time to the issue.

¹⁷⁹ Pennell, J., Edwards, M., & Burford, G. (2010). Expedited family group engagement and child permanency. *Children and Youth Services Review*, 32(7), 1012-1019. (Osterling, 2012; Pennell et al., 2010).

¹⁸⁰ Xu, Y., Ahn, H., & Bright, C. L. (2017). Family involvement meetings: Engagement, facilitation, and child and family goals. *Children and Youth Services Review*, 79, 37-43. <https://doi.org/10.1016/j.childyouth.2017.05.026>

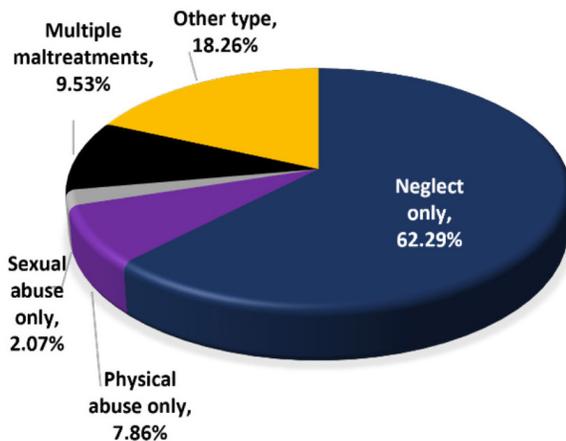
¹⁸¹ Ahn, H., Xu, Y., Williams, K., Bourn, K. P., Williams, S., & Conway, D. (2022). Family team decision meetings and child welfare service disparities: The influence of race and income. *Children and Youth Services Review*, 143, 106705. <https://doi.org/10.1016/j.childyouth.2022.106705>

¹⁸² Children's Bureau. (2020). *Child and family services reviews aggregate report: Round 3: Fiscal years 2015-2018*. U.S. Department of Health and Human Services, Administration for Children and Families. <https://www.acf.hhs.gov/cb/report/child-and-family-services-reviews-aggregate-report-round-3-fiscal-years-2015-2018>

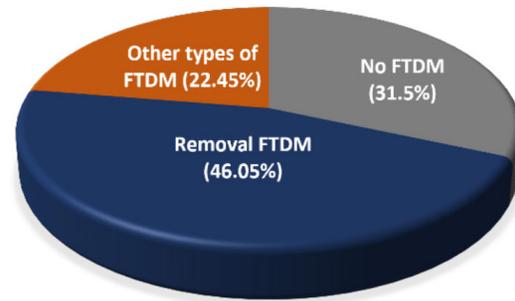
¹⁸³ Ibid.

Figure 26. Sample Characteristics

Maltreatment Type

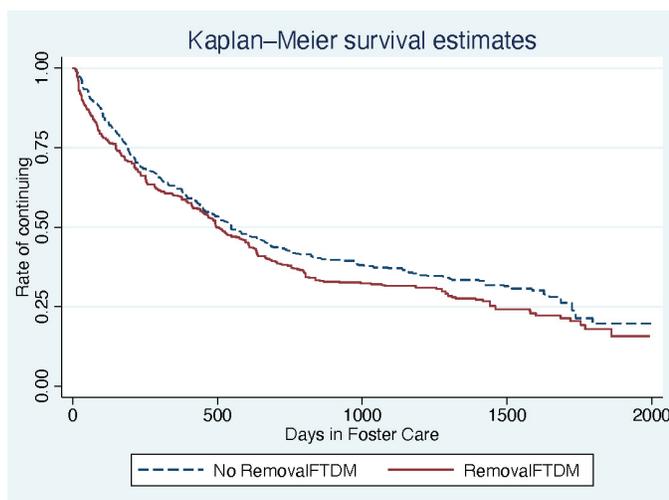


Family Team Decision Meeting (FTDM) at Removal



FTDM meetings are critically important to permanency outcomes and provision of appropriate services. Results from Cox regression models indicate that children removed from the home who received a removal FTDM meeting were 41% ($P < 0.001$) more likely to achieve reunification than children who did not. Among children who achieved reunification, the mean length of time to reunification was 780 (± 34.23) days for children who received removal FTDM meetings, and the mean was 873 (± 33.34) days for those who did not (Figure 27).¹⁸⁴

Figure 27. Survival Estimates of Length of Time to Reunification



¹⁸⁴ Ahn, H., Williams, K., Kolupanowich, N., & James, Z. Survival analysis of factors associated with achievement of reunification among children in foster care. *Journal of the Society for Social Work and Research*, *In Press*. <https://doi.org/10.1086/726342>

Taken together, Dr. Ahn’s work indicates that families that participate in a removal FTDM meeting are more likely to be involved in case planning and in identifying the services they need from the beginning of the children’s out-of-home placement. Results demonstrating the impact of family engagement have important implications for improving safety, permanency, and well-being outcomes for children through child welfare practices. Dr. Ahn was able to share her results with LDSS and child welfare workers, as well as state agencies, to demonstrate the impact of practices on children’s outcomes. Maryland has since updated CWS policy to expand FTDM and change the definition of and requirements for meeting facilitators. Dr. Ahn is currently analyzing data related to reentry outcomes and examining the impact of the use of family teaming on the prevention of reentry into foster care.

Rethinking Child Welfare Investigations and Case Planning: Families’ Experiences with the Front End of the System (Dee Bonnick)

Ms. Bonnick noted that she would typically give her presentation with a core team over the course of an hour but would instead focus on an innovative participatory research project¹⁸⁵ in which she was involved as an individual with lived experience. She indicated that she would discuss ways to integrate lived experience as more

¹⁸⁵ Brooks, J. L., Children’s Trust Fund Alliance, Think of Us, et al. (2022). *Rethinking investigations and case planning: Families’ experiences with the front end of the system*. <https://apps1.seiservices.com/HEAL/docs/Rethinking%20Investigations%20and%20Case%20Planning.pdf>

than a data resource by engaging individuals with lived experience in co-creation, co-design, and co-decision-making. She provided a two-page overview of the project to in-person and virtual participants, available at <https://apps1.seiservices.com/HEAL/docs/Rethinking%20Investigations%20and%20Case%20Planning.pdf>. The project was designed to help fill a gap in research on the front end of the CWS by addressing key questions about the role and experience of investigations and early case planning. These included:

- What is the purpose of a CWS investigation, and when is it necessary?
- How well are investigations serving that purpose?
- How equitably are investigations serving that purpose?
- What should the appropriate response to families in need be?
- What should the appropriate response to families struggling to meet their needs and keep their children safe be?

Project researchers also wished to gather information from parents, youths, and other stakeholders regarding their experiences with investigations, the supports and resources received and whether these met their needs, and how the experiences affected them. In addition to parent and youth interviews, the project collected data through attorney focus groups, a survey of judges, and a survey of CWS workers. The parent interview process was designed by a core research team including members from the CTFA, the Aviv Foundation, Stand Together, Child Focus, and the Annie E. Casey Foundation, as well as five parent members of CTFA's Birth Parent National Network (BPNN) and a research consultant. Both parent and youth interview protocols and processes were designed in collaboration with experts with lived experience, and interviews were conducted by these experts. Ms. Bonnick noted that this participatory approach was new for her, as past opportunities for research participation as an expert with lived experience typically involved review of publications or the provision of feedback on tools that had already been created. Interviews were conducted with 100 parents and 31 young people selected to provide diversity in terms of race, gender, urbanicity, and investigation outcomes.

Ms. Bonnick described her experience as a co-designer of the interview process, noting that all five parent partners desired to speak truth to power, but they also brought their own experiences, expertise, skills, and critical thinking. Parent partners questioned why the interviews were going

to be conducted, given the predictability of interviewee responses and the likelihood that interviews would be traumatic for participants. The research team engaged in lively debates, and parent partners were resolved in their desire not to do anything exploitative of other parents. They asserted the importance of maintaining a level of integrity throughout the process. They said the value of family voices should be central and the process should reflect the dignity and worth of every parent. Initially, meetings with project funders were held separately; team members had expressed concern that funders might be too prescriptive or take up too much time if they participated in project design meetings with parent partners. Ms. Bonnick felt that this decision should have been made based on input from the parent partners rather than preemptively. The project team agreed, and parent partners were integrated into all aspects of the research project, including meetings with funders. Ms. Bonnick participated in subcommittees and was featured in a video sent to parents to explain the interview context and emphasize that parents were in charge of deciding what they wanted to share about their investigation experiences. Interviewees were also informed that parent partners with lived experience had been a part of the core research team and had helped to develop interview protocols and questions. Parent partners were able to participate in all aspects of the research project.

During interviews, experts with lived experience asked parents and youths to share what it felt like to experience an investigation because of allegations of abuse and neglect. Parents indicated that they had found the investigation dehumanizing and difficult, with little to no due process. Parents were acutely aware that the investigating agency could take their children, and fear of that outcome was a common element in their responses. Interviewees stated that they “felt very judged” and “dehumanized through the process” and that it “was like being interrogated” and not “an open conversation.” Many parents sensed that the investigative workers assumed they were guilty. One parent called the process “unfair [and] unjust, especially from a system where you’re always told you’re innocent until proven guilty. When it comes to family welfare cases, that’s exactly the opposite.” Another noted, “They initially approach it and have all those biases. ‘OK, you are doing wrong and just not being fit to raise your kids.’ I feel less than. I feel like less of a human.”

Interviewers met to debrief on what they had heard from parents and to confirm that the interview process had been respectful of parents’ voices. Ms. Bonnick

noted that time and time again, interviewers heard about experiences of abject cruelty, and she requested that workshop participants sit with this information without glossing over it. Reasons investigations were occurring were overshadowed by workers acting cruel and mean-spirited and weaponizing their positions of power. Interviewers heard about investigators' lack of empathy, lack of transparency, and failure to provide parents with information regarding their rights. Parents described occasions when children were removed before parents knew they were going to be removed and cases of investigators ignoring the perspectives of the family and only considering information that was on paper instead of the totality of the human experience of the family. One interviewee also reported, "They were talking at me and not to me." Another said, "Nobody sat down to talk to my family at all and actually figure out what happened, and even when they were given a snippet when I actually did get a chance to tell them what happened, it was still ignored. It wasn't even documented." Many parents felt the workers were going through a routine and were only interested in building a case against them.

Parents also described their lack of power and influence in the process. Many felt that workers had unchecked power over them. One parent reported, "I personally hate the system because I don't think the agency does much good. The people ... are kind of on a power surge and feel they have the right and liberty to remove your children." Others felt and sometimes were told that they did not have any rights or opportunity for input. This is illustrated in the following quotations from interviewed parents:

"I remember there was one part of the case where the caseworker said, 'Your daughter is in a bubble, and one pin prick and the bubble pops and we can remove her from you.'"

"Even when you are doing the right thing, they hold all the power. Who is going to believe the drug addict? They already made it apparent they wouldn't trust me. These people could do whatever they wanted."

"I never felt like I had a voice. ... I was flat out told, 'This is what you will do, or we will take them.'"

"[The social worker] made pretty clear that I really didn't have any rights at the time. 'If you don't agree to voluntarily sign over custody to her father, your rights will be terminated.'"

Interviewed parents also indicated that they did not know they were supposed to receive any services or could get supports to help them keep their children. Many experienced the investigation as a forensic process with a clear intent of removal and did not think that they could ask for help or supports. When services were offered, they did not always address the family's needs or interests or were unavailable.

Not all parents shared the same experiences or had the same impressions of investigations. Ms. Bonnick noted that the most egregious things she heard usually came from Black and brown parents. One family reported having undergone 22 investigations. A woman raising her grandchild was investigated for several years until the grandchild was removed and never seen again. Fathers felt invisible and reported they did not get the support they needed to parent. Parents struggling with substance use felt demonized and belittled. Thirteen parents reported positive interactions, typically with caseworkers who were empathetic, listened to them, withheld judgment, or tried to help them; however, even with these interactions, the overall investigation was experienced as unnecessarily harmful and traumatic.

Ms. Bonnick noted that her experience is that having individuals with lived experience as a part of the research from the beginning as co-creators and co-designers participating fully in decision-making can genuinely change the way research is conducted. She suggested that workshop participants consider the possibility of integrating individuals with lived experiences into their research in ways that go beyond just having them be data sources. True integration can make the research process richer and fuller and has the potential to improve the quality of data collected. Many families interviewed for the presented study thanked interviewers and said it was the first time they had ever been heard and felt supported. They noted that being interviewed by individuals with lived experience made them feel psychologically safe and able to share their stories. The research team followed up a few days after each interview to ask how the participant was doing, whether there was anything else the participant wanted to share, and whether the participant felt that the interview process had been respectful. Ms. Bonnick reported that she felt honored and humbled to be a part of each interview and wrote thank-you notes to interviewees after the interviews to let them know their voices and stories were impactful. More information about the

investigatory process is available; interested parties can contact CTFA at info@ctfalliance.org, and the BPNN is having its 9th Annual Virtual Convening—on supporting families at the front end of the CWS—on June 8, 2023. Registration for the meeting can be completed on the Children’s Trust website.

Session VII Questions

Cecilia Casanueva, Ph.D., of RTI International noted that she was still thinking about the results she had presented for Wisconsin in the context of what Dr. Merritt said about parents believing their children had to be put into the foster care system to receive services or support. She noted that these things could be improved with special location services and individualized education programs (IEPs), and she asked the members of the panel how they were making connections between the different pieces of research they each had presented.

- Dr. Merritt noted that it was disturbing to think that parents believe the only way they can get services or tangible resources is through the CWS. Many parents she has worked with are struggling with housing insecurity and are often placed in shelters through the CWS. Shelters then make reports when parents do things such as go downstairs to get food for their children and leave the children in the shelter room. A large part of the problem begins with mandated reporting, because there are major consequences for mandated reporters if they don’t exercise an abundance of caution when deciding whether to make a report. Teachers who observe children who are falling asleep at their desks or don’t seem to have eaten much can make reports out of an abundance of caution, but if the issues that parents and families are having could be addressed without making a call to the punitive system, it might be possible to be more helpful than harmful. Dr. Merritt has heard repeatedly from parents who feel as if they have to become involved with the system because it is the only way they can get food stamps or a new crib or help dealing with landlords who aren’t dealing with lead or broken appliances when they are behind on the rent and don’t feel they can talk to the landlord without getting into trouble. Community supports are needed. Dr. Merritt indicated that in her opinion, the CWS is not suited to address these types of neglect, and things such as the name of the system, the language used, and the stigma that is attached are too far entrenched

for the existing system to address issues of neglect. She noted that she does not know what a system that could address neglect would look like, but she knows it is not the CWS.

- Dr. Berger indicated that his full answer would take approximately a week but that he would attempt to provide an abbreviated version. He noted that he tends to think of the vast majority of CWS cases as being reflective of constrained opportunities for affected families and as missed opportunities for the public to provide economic support, mental health and substance use services, home visiting services, and a range of other supports. Families that are screened out or investigated with no finding are reported again at a later time at very high rates. And 81% of 4 million reports represent families that could clearly benefit from services and have been identified; however, generally, nothing is provided until the family’s situation gets worse. Dr. Berger stated that services provided once the child or family is part of the CWS are being provided too late. There is a growing body of literature regarding the effectiveness of economic supports, child tax credits, and other ways of providing resources that do not require CWS involvement.
- Dr. Ahn added that the federal requirements for agencies revolve around whether the agency made a “concerted effort” to provide services, and she asked how “concerted efforts” is/should be defined. Many caseworkers report that they made referrals for families, but the families were not able to make appointments to receive services because of issues of transportation, childcare, or work. Making referrals, regardless of whether or not families were able to attend appointments, is often what an agency considers to be “concerted efforts.” From the family members’ perspective, they were not provided with services because of a host of complications. It is important to consider each family’s unique situation and the comprehensive services that are needed.

Ayana Jones, M.A., of the California School of Professional Psychology noted via the chat that the information that had been shared was rich and informative. She asked the panel what other steps were needed to communicate the information to frontline workers in child welfare, policymakers, and others. Funding and time are real barriers to bringing some of these individuals to meetings or workshops, and this is where the important

exchanges are occurring. Are there ways being considered for providing funding or encouraging these untapped and important potential partners to participate in these discussions?

- Michelle Freund, Ph.D., Director of the HBCD Study, indicated that she would share Ms. Jones's comment and question with as many people as possible.

Dr. Gurka noted that she had a follow-up to Dr. Casanueva's question and asked how, if children only receive certain services if placed in foster care, researchers can disentangle the impact of receiving those services from the effect of the difference in care received from a foster care provider versus a birth parent.

- Dr. Berger indicated that this is exactly the point; children receive services when they go into foster care, not at home. When children age out of care, there are a host of services available to them, but when they reunify with families, there are no services available. These are the mechanisms potentially driving positive effects. Children in foster care receive more services and resources and potentially more monitoring through foster care parents. The argument being made is that if a mechanism were in place to provide these strong supports to families, less foster care would be needed or used.
 - Dr. Gurka noted that the data showing that children in foster care have better outcomes than children not in foster care is a challenge because if the effects can't be disentangled, there is an opportunity to claim that the positive outcomes are because of foster care.
 - Dr. Berger reiterated that these are the mechanisms occurring and that disentangling the effects is not the goal, because these mechanisms are the mechanisms that need to be identified.
 - Dr. Jones Harden asked Dr. Berger whether research on children aging out of foster care includes data from children who age out of foster care and go straight into the juvenile justice system.
 - » Dr. Berger indicated that these data are obtained and included.
 - Dr. Jones Harden followed up with a question about how the foster care system can take children from their families and say that they

will be better supported when some children who age out of foster care end up homeless or in prison. She noted that she knows it isn't possible to capture all children who age out and end up in prison, homeless, or even returning to their families.

- » Dr. Berger indicated that his research does include homelessness services data that capture information on homeless individuals in shelters, etc., but not all homeless individuals, and this data set does include a very limited sample. However, the research team does have data on every person in prison in Wisconsin. The research findings he presented were based not on survey data but on records from the Wisconsin Department of Corrections, public schools, the CWS, and earnings records, and these data included the entire population.

Dr. Jones Harden thanked the panel and apologized, indicating that she felt the panel was not given enough time. She noted that the session was very informative and thanked Dr. Freund for her intellectual leadership and for bringing the workshop together. She also thanked every presenter and every workshop participant. She indicated that the workshop had been much richer than she had anticipated and that she had learned a lot and also felt a lot. She thanked participants for joining in the journey, from Dr. Samuels' keynote to the presentation on parent voices to examining and better understanding the CWS to thinking about the connection between criminal justice and substance use services to considering the science. She said the NSCAW, described by Dr. Casanueva, is the best study on child welfare to date. She also noted the importance of presentations such as Dr. Washington's to helping participants understand more about different kinds of caregiving, noted the powerful impact of the racial disparities panel, and emphasized the different research approaches presented in the final panel. The workshop had two goals—to better understand the CWS and to broaden the knowledge of participants about research conducted in this space—and both were accomplished. Dr. Jones Harden indicated that she hopes participants will use the knowledge gained to inform their future research and that it will certainly be used to inform the HBCD Study.



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