TRIBAL CHILD WELFARE FUNDING: 18 YEARS AFTER ICWA

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Introduction

Long before any tribal discussions took place regarding appropriations or legislation tribes used the natural resources available to them to care for their children. Family, community, and cultural traditions, none of which required an exchange of currency, provided the "child welfare services" of that time. The responsibility for protecting children was understood to be a community-wide responsibility with every citizen playing an important role. Today, however, things are much different. The influx of Euro-centric culture and approaches to problem-solving, dramatic increases in the rate and complexity of social problems within tribal communities, and substantial erosion of the natural helping systems that traditionally protected children, have changed how tribes approach the protection of their children. The result of these changes has been an environment in which tribes need to seek out and compete for funding that can support services to protect their children. Today, concepts such as foster care, child protection services, purchase of service contracts and case management, which were almost unheard of little over a century ago, have now become familiar terms in almost every tribal child welfare program.

Now that these changes have occurred, how have tribes fared in securing child welfare funding? The answer is not well. The federal government, which has taken the lead in the development of these resources, has given little thought to the needs of Indian children, the special service delivery system they interact with, and their unique political status. Major sources of child welfare funding, such as Title IV-E Foster Care and Adoption Assistance, have been available only to states to administer directly. Consequently, in order for Indian children to receive the benefits of this program they must be in the custody of the state. Tribal programs are only able to operate or receive funds from this program if they have an agreement with the state. States, in turn, have the ability to control the allocation of funds to tribes and much of the substance of the agreements. This scenario and ones similar in concept are common with a number of other federal child welfare programs making it difficult for tribes to develop and maintain their own programs.

In this presentation and accompanying information I hope to identify the need for increased funding for tribal child welfare funding, the capacity of tribes to provide effective services, and the specific barriers to accessing existing sources of federal child welfare funding.

The Need for Services

The 1990 Census revealed that almost 2 million American Indian people are living in the United States. Approximately one-third of these people live on reservations and trust lands or federally recognized Indian areas with the vast majority of these located in rural settings. The other two-thirds of the Indian population typically live in urbanized areas (Bureau of the Census, 1993). Of this number, 39% are under the age of twenty. Only 29% of the total United States population is under 20 years of age. The youthfulness of the Indian population is in part due to high fertility rates. During 1981-83 the birth rate for Indians was 28.5 per 1,000 as compared to 15.9 per 1,000 for the total U.S. population (Indian Health Service, 1990).

Tribal populations on-or-near reservations range from as few as two people on some rancherias in California to 165,000 on the Navajo reservation which covers parts of New Mexico, Arizona, and Utah. Almost two-thirds of the federally-recognized tribes and Native Alaska Villages in the United States have 1,500 or less people living within their service areas on or near the reservation.

Education

In urban areas, between 45-85% of Indian youth drop out of school with most leaving between the eighth and ninth grades. On reservations and in federal boarding schools the dropout rate is close to 50% (Native American Development Corporation). Of Indian people age 25 and over that live on reservations an average of 54% have high school diplomas or better, while the national average is 75% (Bureau of the Census, 1993).

Health

Indian children and youth have serious health problems, with the leading cause of death for Indian children under the age of 14 being accidents (Indian Health Service, 1990). The chance for death by homicide is 2.8 times higher than that of the general U.S. population (Native American Development Corporation). The suicide rate for school-aged Indian children and youth is 3 times higher than that of their white counterparts (U.S. Office of Technology Assessment, 1986). On some reservations, the suicide rate has increased by close to 200% over the past two decades.

A Congressional hearing on Indian juvenile alcoholism and drug abuse reported that 52% of urban Indian youth and 80% of reservation Indian youth engaged in moderate to heavy alcohol or drug use as compared to 23% of their urban, non-Indian counterparts (U.S. Senate Select Committee on Indian Affairs, 1985). Rates of alcohol abuse in tribal communities are commonly estimated at between 50 to 90% in the U.S. (Hammerschlag, 1982). These statistics reveal the potential for future health problems for Indian children and youth, as Fetal Alcohol Syndrome and Fetal Alcohol Effect becomes more prominent.

Indian Families

The Indian family faces considerable odds in its efforts to provide strong, healthy environments to its children and youth. There are over 442,000 Native American families in the U.S. Over a quarter of these Indian families (27%) are headed by women with no husband present compared to 17% for the total U.S. population (Bureau of the Census, 1993). The median family income for Indian families was $21,700 in 1990, as compared to $35,225 for the total U.S. population (Bureau of the Census, 1993).

Native American people are the most poverty-stricken group in the nation. They are the only group whose average household income has fallen since 1980. In 1989 31% of Native Americans were living at or below the poverty level compared to the national average of only 13% (Bureau of Census, 1993). The poverty rates are even higher for families living on reservations where an average of 51% of the families are living below the federal poverty level (Bureau of Census, 1993).

Unemployment rates for Indian people on reservations are estimated at 45% (Bureau of Indian Affairs, 1991). More than 20% of American Indian housing units on reservations and trust lands lack complete plumbing facilities (Bureau of Census, 1993).

The integrity of the Indian family has been threatened for many years, starting with the involuntary separation of children from their families by sending them to boarding schools outside of their community. This practice has been abandoned, but large numbers of Indian children are still being removed from their families. In 1986, there were over 9,000 Indian children in-out-home placements, an increase of 25% over the number in care in 1980. This constitutes 3.1% of the

total number of children in placement, but since Indian children in the U.S. constitute only 0.9% of the total child population in the U.S., they are being placed at a rate that is 3.6 times greater than the rate for non-Indian children.

Indian children are placed in substitute care more often because of neglect and less often for abuse than the rest of the children in the United States. A University of Iowa study that looked at the factors contributing to child abuse and neglect in Indian and non-Indian families reported that 57% of abuse cases and 85% of neglect cases in the study involving Indian children were alcohol or substance abuse related (University of Iowa, 1993).

Another study that looked at the status of Indian children and families was conducted by the University of Minnesota during 1992 entitled, "The State of Native American Youth Health." This study looked at the health and well-being of nearly 14,000 Native American adolescents across the nation. The findings in this study confirm many of the statistics found in this document. Below are some of the major findings:

Families

- Less than 50% of study participants live with two parents.
- 20% worry about domestic abuse.
- 36% worry about the economic survival of their family and many worry about their parents' use of substances.

Emotional Health and Suicide

- 20-27% of those participating in the study reported being tense, stressed, and burnt out.
- 18% of youth reported having been the victim of sexual or physical abuse or both.
- 21% of females and 12% of males reported ever having attempted suicide, underlying the fact that suicide is the second leading cause of death for Indian adolescents.

Substance Use and Abuse

- 50% of junior high students and two-thirds of senior high students in the study had tried alcohol.
- By 12th grade 27% of males and 14% of females consume alcohol at least weekly.
- 20% of males and 12% of females that are seniors use marijuana on a weekly basis.
- 12% of junior high students had used inhalants.

In the study, many youth with physical health or mental health problems abuse substances. Youth with family problems or who have been abused also reported using substances to excess. The heavy use of substances, particularly alcohol and marijuana, was linked to every single risk behavior mentioned in the report.

Capacity of Tribes to Provide Child Welfare Services

While states and the Bureau of Indian Affairs generally have more length of time operating formal child welfare services, tribal programs have demonstrated that they are generally more effective with Indian children and families. A study commissioned by the Department of Interior in 1978 (Department of Interior, 1988) examined the status of the Indian Child Welfare Act and the role that tribes, states, and the BIA played in promoting compliance. The study found that despite the

increased resources of the BIA and states, Indian children in the care of these programs were more often placed outside of their homes, in more restrictive placements, and stayed in substitute care longer than Caucasian children. The study also indicated that tribal Indian child welfare programs, despite their minimal and sporadic funding, were viewed as doing a credible job.

Another factor that has increased tribal capacity to operate child welfare services has been the continuing movement of tribes towards self-governance, coupled with stimulated economic development on many reservations. Prior to the Indian Child Welfare Act tribal child welfare programs were almost non-existent. The primary providers of child welfare services for Indian children were the state and BIA. This environment provided little opportunity for tribes to develop their own expertise in child welfare or control the means by which services were designed and implemented. State and, to a large extent, BIA child welfare services were modeled after European concepts of child and family. These approaches utilized services that were not suited to what tribes knew were the most effective solutions and many times did not utilize Indian people as primary providers of the service.

Today, however, we see tribal child welfare programs operating in almost every one of the 557 federally-recognized tribes, several with a compliment of services almost as comprehensive as that of nearby states. The services being provided are often hybrid services which exist in no text books or professional journals, but are uniquely suited to the needs of the tribal community. The professionals designing these services are increasingly better educated and trained in Indian child welfare skills, combining the best of new methodologies and time honored approaches to protecting children. The Indian child welfare worker of today is not only developing skills in working with children and families, but also in inter-governmental relations and program development.

A final factor has been the increased activity of tribes to develop service and funding agreements with states, local governments, and private agencies outside the reservation. The average Indian child welfare program can not afford to rely on only one or two sources of funding to support their program. Many of the services that tribes have accessed have been realized through negotiating creative service and funding agreements. Models of these agreements are witnessed in foster care, residential care, child protection, and home-based services to name a few. In some cases, tribes have brokered agreements and marketed their services with nearby non-Indian communities and then reinvested the resulting revenue into more services for tribal clients. Another strategy has been to structure programs so that they may be more attractive to private foundations. All of these ideas have come as a result of a desire to bring more resources to the tribal community, while keeping intact the philosophy and practice that produces healthy outcomes.

Key Federal Funding Sources and Barriers to Their Access by Tribes

While tribes have increasingly assumed responsibility for child welfare services over the last fifteen years, the capacity to develop effective services has been severely limited due to policy related obstacles. Below are listed a number of the primary obstacles. This is followed by a brief description of the funding history and related issues for tribal child welfare programs.

Primary Barriers

- Restrictive program regulations that use "one size fits all" approaches.
- Jurisdictional issues that cloud the timely investigation and prosecution of child abuse cases.
- Geographic locations of tribes to other service providers and the expense of accessing services outside the tribal community.
- Funding sources that offer only a small amount of funding but have demanding application processes and resource intensive administrative procedures.
- The unfamiliarity with or resistance to the Indian Child Welfare Act by many state and private child placing agencies.
- Limited knowledge, experience, and skills of various private, state, and federal agencies in working effectively with Native American families.
- Ineffective consultation processes used by policymakers to consult with tribal governments regarding child and family policy.
- Lack of information available to tribes regarding training, funding, and other resources which might contribute to successful child welfare services.
- Insufficient funding for tribal services needed to provide basic child welfare services.
- Inadequate funding levels for tribal court systems. Many tribes are not able to fund a tribal court system or do not have the funding to be able to develop appropriate codes and hire court personnel to handle child proceedings.

A lack of stable and adequate funding for tribal child welfare programs has proven to be one of the most serious barriers to tribes' ability to protect their children. Before the passage of the Indian Child Welfare Act (ICWA) in 1978, few of the tribes in the United States had resources necessary to operate any kind of child welfare services. Federal and State child welfare funding sources were virtually unavailable to tribes. With the passage of the Indian Child Welfare Act a new grant program became available to eligible tribes for the development and operation of child welfare services. However, while BIA and Congressional estimates stated that approximately $25-35 million annually would be needed to adequately fund these programs, Congress appropriated only between $8-9 million for this program up until 1991. With only about 25% of the funding needed to establish tribal programs the tribal ICWA grant program was run competitively until 1993. Most years this meant that over half of the Tribes in the United States would not receive ICWA grant funds and consequently could not establish child welfare services.

Beginning in fiscal year 1991, Congress began to raise the appropriation level for the tribal portion of the ICWA grant program. In fiscal year 1994 the appropriation level for this program reached $23 million with funding being allocated on a non-competitive basis. While this was a great improvement, funding levels have since dropped, with the current fiscal year (1996) level being enacted at 17 million approximately. Fears that the ICWA tribal program will have to return to a competitive grants process have surfaced again.. While funding has increased almost two-fold since the 80's, the number of approved tribal applicants has increased four to five times.

While the ICWA funding increases and move to a non-competitive process have helped greatly, recent outlooks for federal appropriations under this program remain bleak. However, the funding available from the ICWA has and most likely never will be the single source of funding. Title II of the law speaks to this reality by encouraging the supplementing of ICWA funds with other federal child welfare funding, in addition to authorizing the Department of Interior (DOI) and Department of Health and Human Services (DHHS) to enter into agreements that would promote further sharing of resources. The federal programs mentioned in the law include Social Security Act programs such as the Title XX Social Services Block Grant and Title IV-B Child Welfare Services. Unfortunately, DHHS programs provide very limited funding for tribal child welfare services, with necessary changes in statue and regulation being slow in coming.

State governments also provide little assistance to tribes in the way of child welfare funding. While a few states have attempted to share small portions of either their federal or state child welfare funds there continues to be problems connected with the receipt of these funds for tribes. Common problems for tribes include the small amount of funds available compared to the administrative efforts required, uncertainty of continued funding, and sometimes restrictive guidelines for use of these funds. In many cases, states have been concerned about their liability for passing through federal funds, while also being reluctant to recognize the sovereign government status of tribes. While many tribes continue to work with states to promote the sharing of resources, there remain many serious road blocks that inhibit this process and ultimately the sharing of funding with tribes.

Tribes have now begun looking to other federal agencies that provide funding for child welfare services. The majority of the most stable, ongoing child welfare funding is administered by the Administration for Children and Families under the Department of Health and Human Services. Here the federal governments largest and most comprehensive sources of child welfare funding are located. They are as follows:

Social Security Act Programs

Title IV-B (Subpart 1) Child Welfare Services
Title IV-B (Subpart 2) Family Preservation and Support Services
Title IV-E Foster Care and Adoption Assistance
Title XX Social Services Block Grant

These programs are designed to promote the well-being of all children in the United States; however, most of these programs were designed with little of no consideration given to issues of tribal culture, tribal service delivery systems, or the government-to-government relationship that exists between tribes and the federal government. Consequently, tribes have direct access to funding for only two of these programs, while the two remaining have significant barriers to access based on legislative authority or regulatory guidelines. An in-depth study of these programs and their benefits to Indian children and tribes is outlined in a report from the Department of Health and Human Services, Office of Inspector General's entitled, "Opportunities for ACF to Improve Child Welfare Services and Protections for Native American Children" (August 1994, 0EI-01-93-00110).

As with many federal programs designed to help children federal legislative and regulatory barriers create the greatest difficulty for tribes as they attempt to access the benefits these programs have to offer. The following section discusses the specific problems each of these programs presents to tribal access and recommendations on how these barriers can be removed.

Principles for Effective Tribal Access to Child Welfare Funding

Below are listed the most important principles for any child welfare funding source or service that is going to effectively serve tribal communities. These principles are:

Direct tribal access and administration of funds. This is the surest route to ensuring that tribes can access and utilize the funding effectively. This can be accomplished through legislatively prescribed tribal set-asides funding as has been done in a number of programs, such as the Child Care and Developmental Block grant. Another important component of this principle is the ability for tribes to directly administer and operate the program within their communities.

Funding distribution formulas that are based on not only population, but need. Again, the Child Care and Developmental Block grant is a good example of this type of approach. This block grant program provides a 3% set-aside for tribes and utilizes a funding formula which provides a base amount so that tribes of all sizes can operate at least a minimal program according to the goals of the program.

Regulations that provide tribes the ability to develop and operate programs that reflect their community's values and unique circumstances. Too often federal programs have failed to transfer the original intent of their programs to tribal communities. This has primarily been because of regulations that required activities or services that did not work well within the context of tribal communities. Where regulations have strived to give the community control and flexibility over the types of services that can be offered, tribal responses to child abuse and neglect have shown to be just as effective, and many times more effective than their state or federal counterparts.

Application and administrative procedures that are administratively feasible. Lengthy applications that are required for each funding source, especially when a number of sources have similar purposes and provide small amounts of funding, create a drain on limited administrative resources and sometimes preclude tribes from accessing the funding. Tribal programs have considerable experience in operating a variety of human service programs, but are careful not to take on program operations that are based on large bureaucratic systems. Gaining an understanding of what is administratively feasible for tribes and incorporating this knowledge into application and administrative procedures is the key principle here.

Finally, tribes must be able to have access to technical assistance that adequately instructs them on the goals of the program and the processes necessary to successfully apply for and operate a given program. This technical assistance must include at least a general knowledge of their communities, and service delivery systems.

The following section discusses the specific barriers to effective tribal access and utilization of each of the Social Security Act programs that can provide support for child welfare services. In addition, recommendations are listed that target ways to improve tribal participation and success in each of the programs.

Title IV-B (Subpart 1) Child Welfare Services

This is the oldest federal child welfare program and provided tribes with some of their first non-Bureau of Indian Affairs child welfare funding starting in 1980. The program was designed to provide support for basic child welfare services with few restrictions other than a prohibition on providing foster care maintenance payments. Since enactment, states and in some cases tribes have used this funding to provide for the core services necessary to operate a child welfare program.

Tribal access was based on a provision in the authorizing legislation that gave the Secretary of the Department of Health and Human Services (DHHS) discretion as to which tribes would be eligible and how much funding would be distributed. This very open-ended language in the legislation, along with a regulatory requirement that a tribe had to first be contracting Bureau of Indian Affairs Social Services to become eligible, precluded many tribes from receiving the Title IV-B funding.

In December 1995, the Department of Health and Human Services published a final rule which eliminated the BIA Social Services contract requirement and increased the individual tribal allocation amounts by almost two-fold. In addition, this program has provided what were formerly known as section 427 incentive funds for programs, both tribal and state, that certified that specific protections to children in foster care were provided. As of October 1, 1996 based on amendments to Title IV-B under Section 202 of 103-432 these incentive funds will be blended with the base funds under this program. While states and tribes previously had the option of applying for only the base amount, now to be approved they must also qualify for both the base and incentive amounts. To assist tribes, the Administration for Children and Families, which administers Title IV-B under DHHS, has begun a process to help clarify and revise the guidelines that apply to tribes interested in receiving these funds, while also looking at methods of increasing access for tribes.

The Administration for Children and Families has also helped streamline the application process for tribes under this program. A simplified application form has been provided and tribes are now able to submit just one application for both the Title IV-B, Subpart (1) and (2) programs.

The FY 1996 appropriation for this program is $293 million. As of July 1996, approximately $2.2 million had been awarded to tribes. These funds were allocated to 82 tribal grantees, of which 28 grantees received 427 incentive funds. It is estimated that if all eligible tribes applied, which theoretically is every federally-recognized tribe, the annual allocations to tribes would exceed $8 million.

Recommendations:

1. Provide tribes with opportunities for input as to the needed revisions and areas for clarification during the current process underway at the Administration for Children and Families.

2. Provide technical assistance to tribes on the foster care protections required for receipt of the incentive funds.

3. Improve communication with tribal child welfare programs regarding the availability of these funds and accompanying guidelines.

Title IV-B (Subpart 2) Family Preservation and Support Services

The enactment of this program in 1994 marked a shift in federal child welfare policy by placing greater resources and emphasis on the strengths of families. Previous policy focused more on foster care and adoption as primary means of addressing family difficulties, while this program emphasized keeping the child in the home. Services that are eligible for coverage under this program include, family preservation services which assist families in crisis, where a child is at imminent risk of being placed in out-of-home care because of abuse and/or neglect. Family support services which are preventive activities with the aim of increasing the ability of families to successfully nurture their children, such as parenting classes, respite care, and assistance in obtaining benefits. In addition, this program focused on systems change as a necessary component of reforming the way child welfare is done at the local level and the leveraging of additional resources that support child and family well-being.

The authorizing legislation provides a 1% set aside of the total funds for distribution to eligible tribes. However, a separate provision in the law only allows funding to be distributed to tribes that would otherwise receive at least a $10,000 allocation based on a population-based formula in the law. The combination of the small set-aside (remembering that the Child Care and Developmental Block Grant tribal set-aside is 3%) and the restriction of funding tribes only with allocations of $10,000 or more has provided the benefits of this program to only a small segment of federally-recognized tribes.

The current tribal allocation for fiscal year 1996 is $2.25 million going to approximately 57 tribal grantees.

Recommendations:

1. Amend the authorizing legislation to increase the tribal set-aside to 3%.

2. Amend the authorizing legislation to eliminate or significantly reduce the $10,000 restriction on funding eligibility for tribes.

3. Include in the upcoming regulations language that encourages and authorizes tribes to apply as consortia as they have with Indian Child Welfare Act grants for many years.

Title IV-E Foster Care and Adoption Assistance

This program was designed to help provide for the actual maintenance payments needed to support foster care placements and support services in both foster care and adoption assistance. Eligible services included foster care maintenance payments, case management services related to foster care and adoption assistance, and services to assist adoptive children that have special needs such as physical, mental, or emotional handicaps.

States were legislated to be the primary administrators of this entitlement program. Tribes were given no authority under the law to administer the program directly and consequently the law does not allow children placed by a tribal system in a tribal foster home to receive IV-E payments unless the tribe enters into an agreement with the state. This has led to the development of IV-E intergovernmental agreements between some tribes and states that provide an opportunity for tribes to administer portions of this program. However, these agreements have not been without controversy. Some of the barriers to the development and successful maintenance of these agreements include:

- State liability for providing IV-E funds to tribes. Under current law a state providing these funds is accountable for tribal compliance with IV-E guidelines. The state faces the possibility of losing IV-E funds if a tribe is out of compliance.

- Unresolved conflicts between states and tribes. In some situations, issues which may be unrelated to child welfare which have resulted in conflict between tribes and states may provide a roadblock to the formation of other agreements. As an example, a state and one or more tribes may be involved in a protracted land claim or jurisdictional dispute. The negative fallout from this dispute can spill over to other agencies resulting in a reluctance by either party to form agreements on child welfare issues.

- Lack of control that tribes have over the IV-E agreement process. Tribes trying to develop Title IV-E agreements with states have experienced a variety of responses. In many cases states are reluctant or even opposed to forming agreements. In some other cases states have asked to place a cap on how many eligible Indian children tribes could place and receive

funding for. Finally, some states are only willing to allow tribes access to the foster care maintenance payments and not the administrative funds. These barriers have often resulted in tribes not pursuing IV-E agreements, leaving Indian children without benefits from this program.

One of the only alternatives available to tribes that cannot administer a IV-E program is to give state courts custody of their tribal children in order to access needed foster care resources. This a choice that many tribal leaders and Indian child welfare experts see in direct conflict with the intent of the Indian Child Welfare Act which reaffirms tribal jurisdiction over child welfare matters involving their tribal members.

Recommendations:

1. Develop legislative amendments to Title IV-E that give tribes direct access to the funding from this program and enable them to administer the program within their own communities.

2. Waive or significantly reduce the amount of matching funds for tribes to a level proportionate to their economic base.

3. Develop regulations for tribal administration of this program that reflect the realities of tribal child welfare service delivery systems and provide some flexibility in the operation of this program.

Title XX Social Services Block Grant

This block grant is one of the most flexible sources of federal social service funding available. States often use it for a variety of services, some of which are child welfare related. The typical services provided with these funds includes child abuse and neglect prevention, protective services for children and adults, special services for children or adults who have disabilities and services to promote economic self-sufficiency, and a wide variety of other social services

The FY 1996 appropriation level for Title XX is $2.3 billion dollars, which is only distributed directly to states and territorial governments. When the block grant was authorized in 1981 little thought was given to the impact of funding tribes. Thirteen years later only six states report any sharing of Title XX funding or tribal involvement in planning for services supported by Title XX funding. Of those states that do share some of their Title XX allocation with Tribes, most only share a very small amount. This is in spite of the fact that state allocations of Title XX funding are based, in part, on the total state population including tribal populations.

Recommendations:

1. Amend the authorizing legislation for Title XX to reserve 3% of the total appropriation for allocation directly to tribes.

2. Develop regulations for tribal grantees that maintain the flexibility in the development and operation of Title XX services that is currently in the law.

3. Develop language that requires states to include tribes in their planning for services supported by Title XX funds.

Discretionary Funding

Every year the Administration for Children and Families prioritizes activities and distributes grant funds that support those activities. In the past, this planning process has resulted in the targeting of funds for child welfare projects that benefit tribes such as child abuse and neglect prevention and the development of intergovernmental agreements between tribes and states on child welfare matters. These projects have contributed a great wealth of knowledge and support to the protection of Native American children. While these projects have advanced some important issues, further investment from the Administration for Children and Families is needed. The first area identified below was funded once in 1992 but has not seen widespread implementation because of funding shortages that can support this type of work. The second area has not yet been supported by Administration for Children and Families discretionary grant funding but is equally important to tribes being able to improve their ability to operate successful child welfare programs. Each is described in more detail below.

Tribal/State Child Welfare Agreements. These agreements have proven valuable in clarifying the roles and responsibilities of tribal and state governments regarding the provision of child welfare services to Native American children and families. In many situations these intergovernmental agreements provide a framework in which to improve compliance with the Indian Child Welfare Act and initiate additional improvements for tribal and State services. The Children's Bureau has previous experience in funding these types of grant projects and should continue to prioritize the funding of these projects. The benefits from these agreements will be felt far into the future and will help both states and tribes work towards improved relationships and coordination of services for Native American children and families.

Training and Technical Assistance. Tribes have only had funding for formal child welfare services available to them during the last 15 years via the Indian Child Welfare Act, Title II grant program. Because the first 13 of those years utilized a competitive grants process many tribes have had child welfare programs for only a year or two. Training in basic child welfare practice and program development are essential to the successful development and operation of these programs. The Bureau of Indian Affairs and Indian Health Service have provided little in the way of effective training or technical assistance, leaving tribes in a vulnerable position as they attempt to build their capacity to operate child welfare programs utilizing multiple funding sources, some provided by the Children's Bureau. Providing ongoing resources in these areas for tribes by utilizing experienced professionals in Indian child welfare will ultimately benefit both tribes and the federal government.

CONCLUSION

This document has provided a general description of the current status of Native American children and families and issues involved in trying to access resources that can improve their health and well-being. While tribal leaders and community members have the insight into what the most effective solutions are for improving conditions for their children, sadly, the resources to support these solutions are either not available or are very difficult and time consuming to access. The foundation principles in this document to effective solutions are direct tribal access to funding and services, community-based programs, more even correlation between intensity of administrative effort to amount of funding available, and greater flexibility in the design and operation of programs.

In relation to the Social Security Act programs, the solutions mentioned in this document are, in most cases, remedies to what were probably inadvertent oversights during the early stages of development and implementation of each program. More recent family policy adopted by both Congress and the Administration has demonstrated a commitment to the principles of the long

standing government-to-government relationship that exists between the tribes and federal government. Moreover, now is the best time to change these programs and develop policies that reflect this long standing relationship. As the Administration has stated many times, and is commonly acknowledged in Indian Country, community-based programs that are less bureaucratic and emphasize the strengths of each community have the greatest success of any programs.

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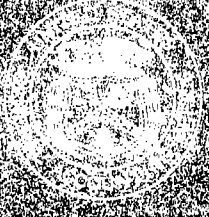

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GUIDELINES FOR DECISION-MAKING IN CHILD WELFARE

Case Assessment, Service Planning and Appropriateness in Service Selection

Sister Mary Paul Janchill, D.S.W.

Selected pages

This handbook is published under a contract between the New York State Department of Social Services and the Human Services Workshops (sponsored by Sisters of the Good Shepherd Residences). Additional copies may be obtained by writing

The Human Services Workshops
12 West 12 Street
New York, New York 10011

Typeset by Type Network in 11 point California
41 Union Square West, New York 10003
(212) 243-0334

Printed by Noble Offset Printers, Inc.
New York City

Cover designed by Dennis Leder

Preface

During this past decade, human services professionals and government officials in New York State and throughout the country involved in the area of child welfare have expressed concern regarding the social, personal and fiscal costs of substitute care of children, and have become aware that, in many cases, the children should not have been removed from their homes or are inappropriately placed within the foster care system.

In 1974, the New York State Board of Social Welfare set out to examine these issues through a study of the New York City foster care system. The foundation for this study was a set of criteria for foster care placements and alternatives to foster care written by Sr. Mary Paul Janchill of the Sisters of the Good Shepherd Residences, especially for the study. The criteria embodied both current child welfare theory and experience with the New York City system, both residential care and alternative services. Although some people disagreed with the application of the criteria on the grounds that some services were available in extremely limited supply, there was wide acceptance of the concept and approach to the problem.

In the time that has passed since the original publication of the criteria, it became increasingly clear that the State must also implement a control and review mechanism which will insure that children are not inappropriately removed from their homes and that those who are removed are placed in the least restrictive environment possible. Accordingly, in early 1979 as part of a task force formed by the Governor to study these problems, Sr. Mary Paul was asked to describe an approach to assessment that would provide a basis for decision making set forth in the original criteria. This document contains both her protocols for assessment and an expanded and revised version of the criteria for decision making.

In July of 1979, the State Legislature passed, and the governor signed, the Child Welfare Reform Act. This legislation addresses the need for utilization controls and preventive services to keep children out of foster care or return them home. This legislation represents the integration of a concern for civil liberties, social policy, case management, and fiscal concerns and issues.

Although the State has not yet reached a determination regarding the final form of utilization review, this updated and expanded version of Sister Mary Paul's original work still represents seminal thinking. While it does not have the force of State law, regulation or policy, it does represent one method for addressing the issue of utilization review, and a model that we are actively considering. At the very least, this document represents an important contribution to professional literature in child welfare.

Barbara B. Blum
Commissioner
New York State Department of Social Services
March 2, 1981

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PART I

Principles and Methods in Case Assessment and Service Planning

Across New York State and throughout the country, very large numbers of parents have yielded to government the responsibility for care of their children. Some do this on their own initiative, because they are under severe stress and feel unequal to the tasks that are involved in rearing children. The context of stress varies considerably, but it usually includes both psychological and environmental dimensions. In some instances stress is an effect of handicapping conditions in the child such as severe physical and/or mental impairments. Government itself takes jurisdiction over children in certain cases of documented neglect or abuse. In still other cases, children are removed from their homes because of their delinquent behavior, as the public's exercise of social control either to protect the community or the child from harmful consequences. If runaways and other unhappy youth could be the petitioners for help in their own behalf, it is likely that additional numbers would be laying claim to care outside their homes.

The social, personal, and fiscal costs of substitute care of children have reached such proportions as to generate widespread alarm. From many quarters and from a variety of perspectives have come accelerating demands for control over the flow of children into substitute home care, and demands for alternatives which would constitute "preventive services". Tracking the costs of foster care, whether in foster family homes, group homes and residences, or institutions, within a history of rising expenditures, has been very influential in a universal search to induce an attrition in "admissions to placement".[1] There has also been a common

1. Costs are usually ascribed to payments directly made to providers of foster care; rarely do the figures cited include the local, state and federal expenditures for administration, supervision, accountability tracking, etc. It is possible that in some instances such costs could exceed the payments for direct care. Burgeoning expenditures for complex, computerized information retrieval systems are another set of costs.

recognition that the remediation of parent or family-related problems has often lagged far behind the activity devoted to the day-by-day care and management of the child or children going into placement, since foster care is usually a child-rather-than-family service preoccupation. There is, too, widening knowledge that children who are rescued from an apparently failing family are often traumatized and damaged by the very process involved as well as the insecurities that attend substitute care. Surely any social worker who has had direct practice experience in the field of foster care, or who has participated in research and case reading, can document numerous instances of emotional disturbance in children directly associated with reactions to separation, ambiguities in the status of foster child, and uncertainties about the sources of influence and decision-making shaping their lives.[2]

Notwithstanding the strong public interest in reducing the use of foster care, virtually all studies make the caveat that this service is necessary and helpful for *some* children, in *some* circumstances, and beneficial to *some* parents as well. Standard-setting is, then, an essential professional obligation and a requirement of social policy. We should be able to see *some* narrowing in the wide margins of uncertainty which attend decision-making in the child welfare field. Nevertheless, we are not here advocating adoption of "decision-tree" models which give formulae for the reduction of uncertainty. Caution is also in order in scanning certain "symptom" lists which are said to constitute protocols or indices for decision-making. The human situations in which professionals and social agencies make their decisions require, above all, sensitivity to the individual child and parent, an understanding of human development in both psychological and social terms, knowledge of how social systems and social resources can be dynamically involved in both the creation and solution of problems, and how motivations toward competence are fostered. Sound decision-making needs more than a delineation of problems. For most problems, in fact, there are a variety of conditioning or causative factors, a variety of contexts in which they are expressed, and therefore a range of responses from which one needs to choose in the offer of help. Also, it is extremely important that helping occur, as far as possible, with the voluntary participation and consent of the "client", including children old enough to make their feelings and needs known.[3]

For all these reasons, there are few short-cuts available to a responsible decision-maker. Confidence in the reliability of the decision-making is very closely associated with the very process of helping to meet the needs of the client. One finds these needs not only from a careful and sufficient location of problems, but an

2. See examples cited in Nadia Ehrlich Finkelstein, "Children in Limbo", *Social Work*, Vol. 25, No. 2 (March 1980), pp. 100-105.

3. For a serious discussion of this, see Willard Gaylin, Ira Glasser, Steven Marcus and David Rothman, in *Doing Good: The Limits of Benevolence*, New York: Pantheon Books, 1978.

interpretation of the situation as experienced by the person, the themes that constitute that experience, the quest for self-actualization which may appear active, dormant or displaced negatively, and how all of these are met by the environment of persons and systems with which the individual is in transaction. This is the essence of case assessment; this is where uncertainty gets reduced as one pursues what it takes to "do good" to children and their parents.

There are certain operational principles in child welfare which need implementation for valid decision-making and service planning, based on the above considerations.

Fundamental Practice Principles

The following practice principles are proposed as standards for workers who confront situations where children are at risk or being considered for out-of-home placement:

1. Fact-finding, case assessment and evaluation, should precede any placement decision. In cases of emergency, where immediate action must be taken to safeguard a child's safety, the sense of the emergency must include the need to know the child and family through information imnmediately sought. No time should be lost in working toward a full assessment of needs and potential.

2. The public agency carries the ultimate responsibility for case assessment and decision-making in all situations which are referred to it for services. The importance of timing and of sufficiency of knowledge should cause the public agency to seek the assistance of social agencies, school, relatives, clergy or others who have been or could be constructively involved with the family. Often the collaborative participation of one or more of the above is essential for an adequate assessment. In every case in which a child is placed because of a life-threatening emergency without prior intake or assessment information, the foster care agency accepting the responsibility for the child should play an active participating role in the case study. In such emergency cases the public agency may delegate to the foster care agency the responsibility of case study if the agency has the professional capability to do this.[4] A thorough case assessment should be done within thirty days of a child's removal from home in emergency situations.

3. In the case of unusual obstacles to fact-finding and assessment (e.g., desertion of parents or other basis for their inaccessibility, need to clarify a complex medical situation, or a legal impediment to interviewing a key figure in the situation) every effort should be made to develop a psychosocial assessment to the fullest possible extent, making specific mention of those areas which need completion.

4. Foster care agencies which provide emergency care as well as other residential services and programs must have both the capability and commitment for study encompassing a family-centered reference, lest bias and economic incentives cause them to screen children into "long term" foster care.

Cooperative interagency relationships (often best developed by the respective workers themselves) will enhance effective case study and planning.

In protective service cases where there may be a 90-day time frame set by statute for an official determination ("indication") of neglect or abuse, there should still be a push to arrive at psychosocial assessment and a preliminary service plan within the first thirty days. Crises can easily harden unless energies are mobilized from the outset.

4. There must be a logical relationship between the needs assessed and the selection of service methods. For example, a finding that a youngster's health and development are jeopardized by an unsafe housing situation should be addressed by housing relocation for the family, not by placement of the child. In the case of a child who is the victim of incest, if supervision and treatment of the victimizer cannot be safeguarded, consideration should be given to removing that person rather than the victim. In cases where home management and hygiene are deficient, in-home services are relevant. If it takes a combination of community-based support services to maintain a family, then that should be the substance of the service plan.

5. Where emotional, social, behavioral, health or educational impediments are in question, there must be an adequate survey of potential remedies. The choice of task, strategy and resources should include study of the choices, resources and motivations of the family members themselves. Steps to out-of-home placement should not be taken without satisfying the question: "What needs to be safeguarded or provided that cannot be achieved in the community?" And care must be taken not to underestimate or overlook options which can be found or designed.

6. Since the service plan developed with the child and the family should be consistent with the assessment of needs, the intervention chosen should follow the principle of "least restrictive alternative." An emotionally troubled child should not be placed in a psychiatric facility if it is possible to address his/her needs in a foster family or group home which is supported by good mental health services. A physically handicapped child should not be placed in an institution for such children if nursing supervision could be provided in-home, in a foster home, or group care setting in that order of choice, depending on the whole set of needs observed and the resources available. Children who need to be placed out-of-home should not be sent at a distance from their families unless a parent is so disturbed as to endanger the youngster; more on this subject below.

The principle of least restrictive alternative is more than a civil liberties mandate: it is a principle of authentic treatment management. Social segregation often removes an individual from the very social systems which are the source of psychological growth, maturation and life skills development. While a given community or neighborhood may appear to have noxious influences, it is important to search out and consider the use of social resources in the community which can be valuable elements of a service plan. Pursuit of the least restrictive

alternative is closely associated with appropriate matching of services to specific needs. The premise here, then, is that the service plan needs to be much more than a problem-oriented arrangement.

Protection of this principle goes to the heart of reform in child welfare, since many studies have shown a disproportionate representation of poor and minority group children in restrictive and residual settings.[5]

7. The logic of task formulation based on all the principles set forth above, applies to protective service cases as well. A finding of neglect or abuse requires more, rather than less sensitivity to human and social dilemmas and responses.

It has been said that in protective service cases, the public social agency "has the legally mandated responsibility for ensuring that preventive, evaluative, and treatment programs are responsive first to the needs of abused and neglected children and then to the needs of their families".[6] Even with the responsibilities of protecting children who are dependent on adults for their safety and well-being, care must be taken to avoid setting the needs of children and parents in antithetical terms. In actuality it is most often by responding effectively to the parent (family), that a child's protection is addressed. Saving children is very often a matter of saving families.

The principle here is to ascertain whether supports provided can protect the *capacity of the parent* to sustain the child, or whether one has to find a substitute for the parent because of the severity of psychopathology, inability to parent, or irreversibility of the problems involved.

A Conceptual Framework for Case-Assessment and Decision-Making

The cornerstone of sound social work practice is an adequate case assessment. In child welfare situations, where decision-making and choice of services take on critical consequences, one cannot overestimate the importance of a quality assessment. How is that achieved?

Ordinarily, an individual comes to the attention of a social agency with a "presenting problem", an issue, conflict or need which precipitates a request for help either by the person him/herself or an informant who has elicited or observed a problem. That initial request needs to be reviewed with the prospective client in the light of that individual's perceptions, feelings, experience and environmental context. To gain an understanding of the meaning of the problem and where a

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5. Some of the relevant studies are cited in Murray L. Gruber, "Inequality in the Social Services", *Social Service Review*, Vol. 54, No. 1 (March 1980), pp. 59-75. This article also presents a cogent analysis of how class and race factors get reflected in a "downward drift" in the rationing of services.

6. James L. Jenkins, Marsha K. Salus and Gretch L. Schultze, *Child Protective Services: A Guide for Workers*, National Center on Child Abuse and Neglect, Office of Human Development Services, U.S. Department of Health, Education and Welfare, DHEW Publication No. 79-30203, 1979, page 7.

helping process might begin, the social worker needs to survey the life situation of the person, whether child or adult. Individuals experience conflict, anxiety and stress in different ways and to different degrees, especially as problems cross one or more areas of their lives. Stress may be limited to certain areas of relationship in a family—or, it may include, derive from, or spill over into other life systems such as the physical, economic, educational, vocational, friendship and social areas. When problems exist in any one of these dimensions of the life space, more frequently there tend to be reverberations in other life systems. There are different clusterings of the effects of stress, different ways in which people compensate or create solutions which are psychological, on the one hand, and affect functioning and action on the other. In child and family problem situations, it is important to take these considerations into account in the case assessment. It is also essential to look at the physical aspects of environment. No single problem category or feature of a child or parent's functioning is an adequate guide to decision-making and selection of services.

Neither can there be a direct correspondence between a "diagnosis" and a service plan in the human services, as sometimes exists in medicine. Persons with a similar diagnosis given in psychiatry (e.g., by terms such as "thought disorder", "affect disorder", "borderline personality", "schizophrenia", "narcissistic personality", etc.) will require and/or accept help in widely divergent ways, depending on life history, personal attributes and experience, and ecological context, as well as internal and environmental assets and resources. A child welfare worker certainly needs to understand family dynamics, child development, and the pyschology of individual behavior; also greatly needed is an understanding of the social psychology of people in ethnic groups and cultures, of institutional systems like schools, welfare centers, social agencies, health centers and hospitals, courts, housing and employment sectors. It is in the very process of a systematic survey of life space areas and in the understanding of the interaction of personal/environmental factors, that one needs to "take in" possibilities for problem modification and support to the individuals involved. It is important that in thinking about services and the forms they should take, one locates those possibilities through study of the same personal and social systems, life areas and institutions mentioned above. Yet there is no one-to-one correspondence between a given problem and a suitable solution. For example, one presenting problem many social agencies receive consists of a mother given to physical punishment of a hyperactive young child. Such a mother may freely admit to her inability to control her anger and "temper" in both scolding and hitting. Along with a study of the nature and context of that hyperactivity and what can be done to ameliorate it, a sensitive, holistic assessment of the mother's personal experience and the family environment may indicate the value and salience of a service such as:

- a foster grandparent's part-time presence in the home to provide the young mother, as well as the child, affirmation, relief and enrichment.

- family day care for the child in order to permit the mother to have a part-time job which is selected for the gratifications and success possibilities it holds for her.
- a self-help group of mothers who have had problems related to child abuse.
- a family life education program dealing with issues of early childhood development.
- a casework relationship which seeks to deal with designated areas of stress causing displacement on the child.
- a change of apartment or other environmental condition, in order to bring about a more supportive setting for mother and child.
- helping the mother to overcome the problems of social isolation or estrangement and to connect with a congenial social group, relatives or friends, so that she can give more to her children.
- setting up a structured monitoring systems for the control of incidents while help is given the mother to modify her handling of the child.

The list could be much longer. The emphasis here is in the *principle* that inducing change in one life area may likely affect another. One thinks this way in looking at the problem and potential response by searching out normalizing, developmental and energizing strategies. This is not to ignore the weight of psychopathology or disability which may be present in some situations, to some degree; it is to recognize, however, that the *very management of that pathology or disability* may require competence building, access to material or environmental relief, or social supports. Thinking this way—of how to manage what might be called a treatment task—is critical in decisions regarding the removal of a child from home and finding substitute parents, or supporting parental capacity within the home. It is also influential in establishing a milieu within which the worker and individual family members arrive at the tasks they will choose to work on and share.[7]

Therefore, the proposal made here is that the frame of reference for case assessment should be very consistent for case planning. This should be the logic for the selection of services and assurance of appropriateness.

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7. There has been a recent and strong emergence of interest in the usefulness of written contracts setting forth the respective tasks of client and worker. In one agency service model, the contract is also signed by participating agency representatives. The difference between the managerial emphasis in contracting and the approach suggested here should be apparent. For a reference to the former, see Harold H. Weissman, *Integrating Services for Troubled Families*, California: Jossey-Bass Publishers, 1978.

The Methodology of Protocols for Assessment and Planning

In order to render the process of *case assessment and choice of task and service* consistent with the conceptual framework discussed above, a method of laying out protocols (a set of *dimensions* which guide the analysis and action plan) is now presented.

Utilizing the attached diagrams as a guide for a systematic and thorough analysis, the worker making the assessment relates to the major life space areas of the family or individual client to derive

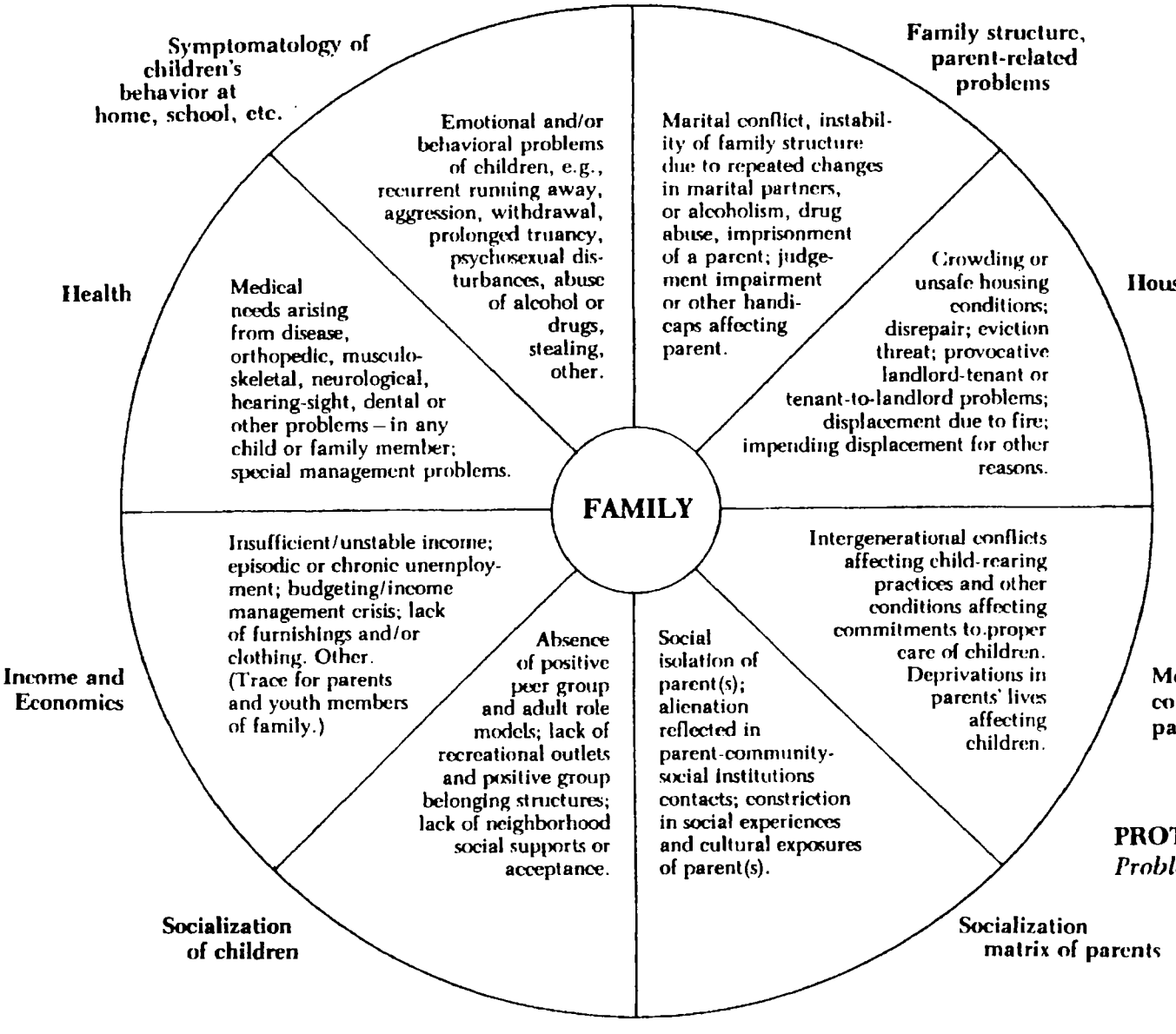
(1) the dimensions of problems and needs in their extent, severity, duration, and interrelationships (Protocol Diagram I);

(2) the dimensions of strengths and assets of the family or individual under consideration, as reflected in personal qualities, relationships, as well as available motivations, commitments, and external or environmental resources (Protocol Diagram II); and

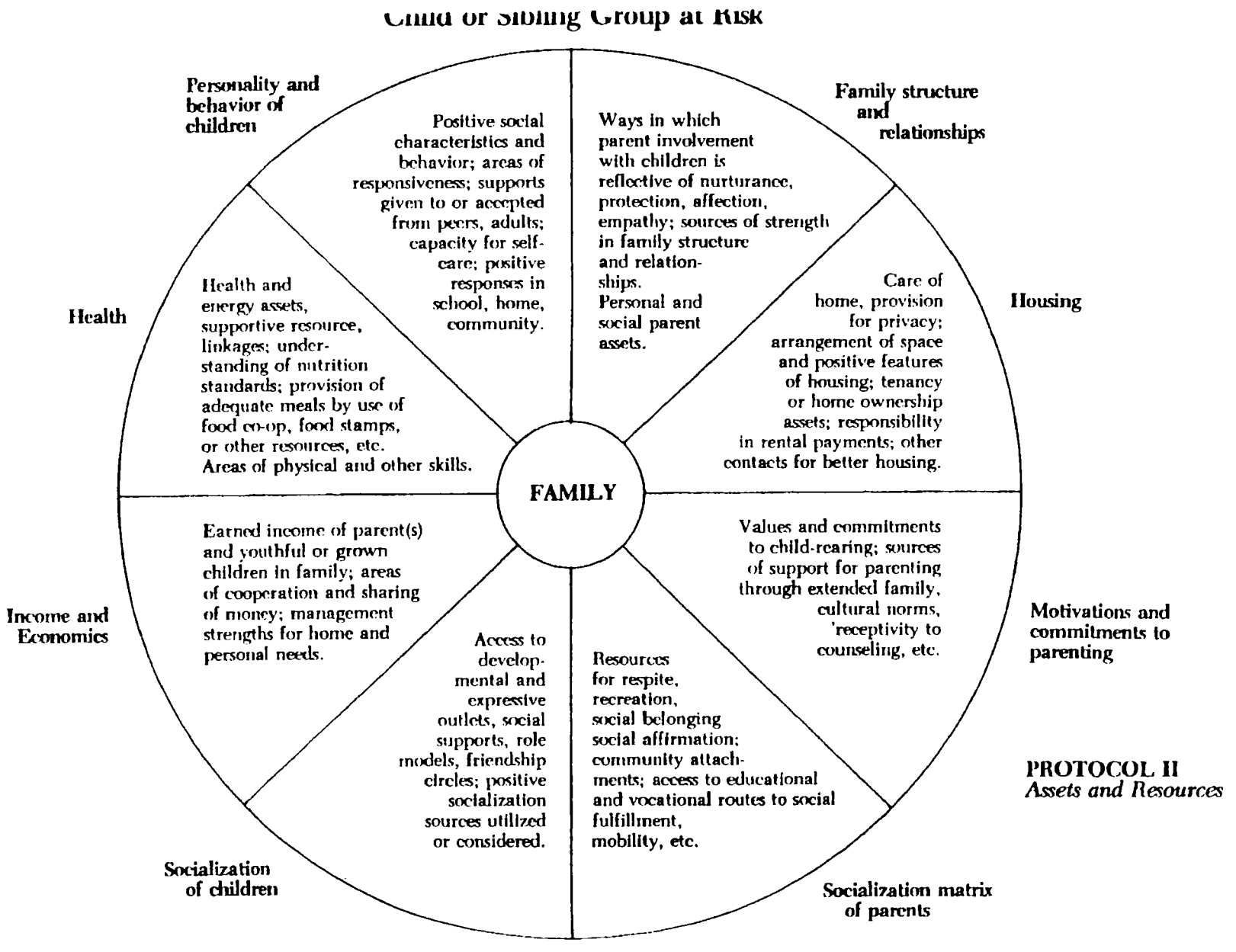
(3) the points of leverage for the reduction of stress, improvement of personal function, amelioration of pathology, or building up of support systems—as tasks to be shared by worker and client either in a direct service or by linkage with resources and opportunities (Protocol Diagram III).

The diagrams for Protocols I, II and III, respectively, presented on pages 12, 13 and 14 of this monograph, are suggestive rather than definitive or exhaustive. Each of the life space areas laid out is briefly annotated to indicate the *possible* content to be explored. Clarity about the conceptual framework for case assessment discussed above will lead the worker in his/her exploration of the client's personal experience and life situation, to draw out the analysis appropriately and particularly. Areas that are problem-free will be presented as significant also. The survey involved in this serves to individualize as well as synthesize.

Child or Sibling Group at Risk

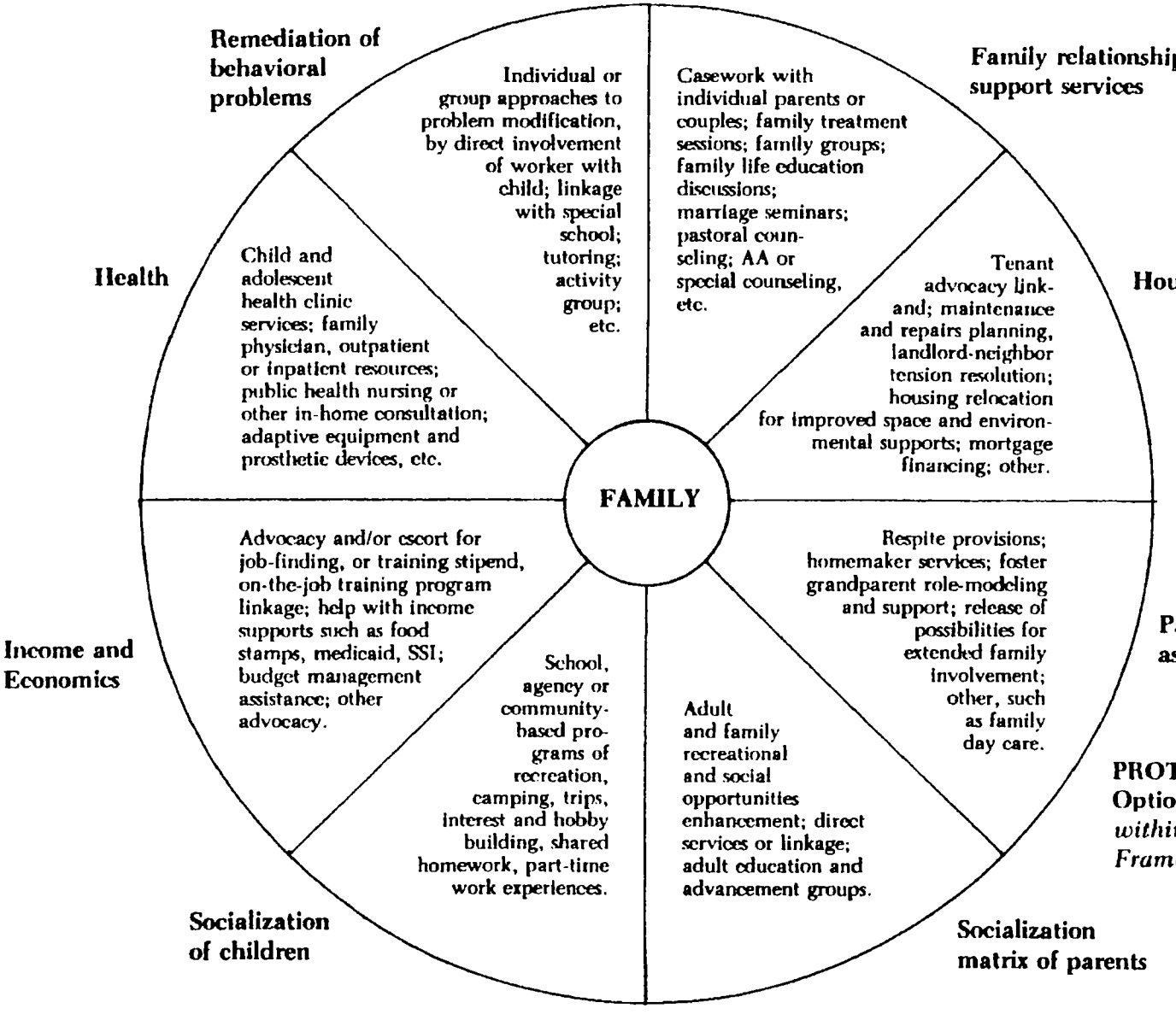


PROTOCOL I
Problem & Need Analysis



PROTOCOL II
Assets and Resources

Child or Sibling Group at Risk



PROTOCOL III
Options in Support Services
within Case Management Framework

Developing the protocols so that they yield a full and sensitive assessment as well as guides to service planning, requires that the worker conducting the study is attentive to the unique personalities involved as well as the contributions of significant relationships with impinging social systems: an emphasis repeated so that one would not limit the protocols to a simple inventory or litany of problems, etc. Space does not here permit a review of the principles of interviewing and the skills involved. While information from related sources and collaterals is often very important, effectiveness in the assessment and appropriate selection of services is ultimately contingent on the confidence the client acquires that he/she is understood. Frankness and directness, so important in protective service cases as in others, can go along with empathy, respect and acceptance. The ability of the worker making the assessment and service plan to see problems as multi-dimensional and interactional facilitates the kind of exploration clients are apt to appreciate more than if one "harps" on the external facets of a complaint alone.

The use of the protocols is appropriately carried over in specific service plans which are to be implemented by a "preventive service" agency, or whenever a child does need substitute care in a foster family or group setting. In actuality, appropriateness of care criteria are fundamentally related to two principles: consistency of the selected form(s) of service with the range and kinds of needs assessed (the whole of the rationale for the decision); and the principle of least restrictive alternative. These two principles are actually interactive. The choice of the least restrictive option must be consonant with the matching of problems and needs with relevant tasks and strategies. In these terms it is always inappropriate to place a child in any form of foster care because of insufficient income or housing or the economic dependency of natural parents; it is inappropirate to place an autistic child who is in need of very consistent, individualized handling in a large institution where there is a multiplicity of handlers working in shifts; it is inappropriate to place a handicapped child because he/she is too heavy for the mother to lift in bathing, etc., since lifting and physical care can be addressed by in-home services, bathroom appliances, etc., when family members are able to give emotionally to the child.

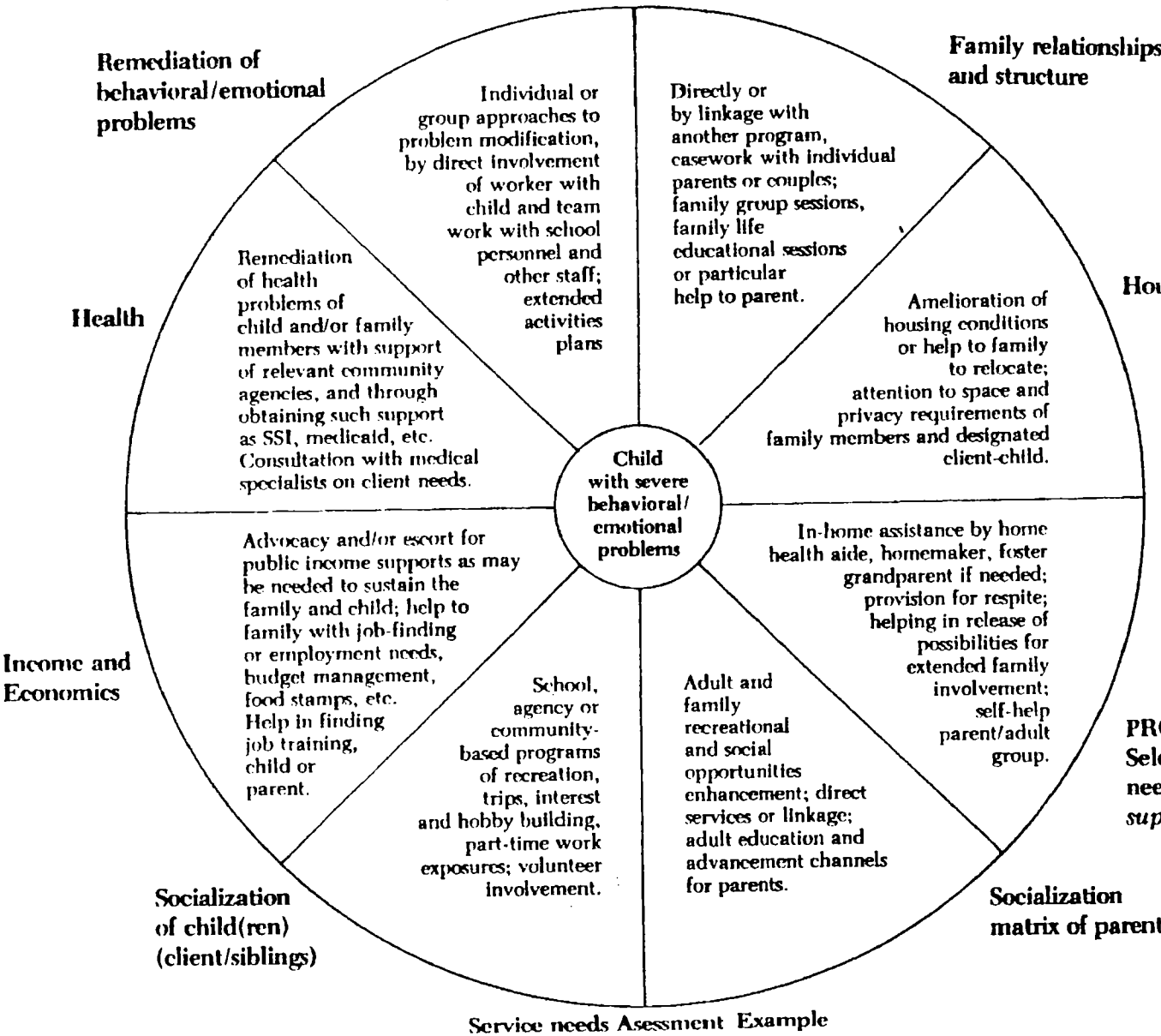
It is recommended that a set of protocols similar to those illustrated in the foregoing pages be used to develop a specific service plan when any child goes into a day treatment program, foster family or group setting, residential treatment center or any other residential alternative. Usage of this method of studying problems and needs to delineate goals for the service plan, specific action steps and resources to be called upon, and relevant tasks which the service plan lays out for monitoring, is a kind of "insurance" that the basic rationale for the program assignment will not be lost. It is well known, for example, that a situation of "drift" in prolonged foster care frequently occurs because family issues are lost sight of and go unaddressed, while caretakers concentrate on child management in the program setting. It is common, too, that problems of behavior and functioning in children are often associated in the minds and writings of diagnosticians with sociological

conditions, parent-child relationships, poverty and unemployment, or educational system unresponsiveness, while the actual service activity sets such factors aside in the program itself. It is rare, for example, to find staff of a children's psychiatric hospital addressing family and social system issues identified as relevant to the child's status! So is it rare when children are sent to mental retardation or correctional agencies.

Use of the protocols to analyze the needs of children and their families in the light of their experiences and human ecology provides a basic structure for ongoing planning. It also constitutes a framework for the process of *utilization review*, a recent legislative mandate in child welfare in New York State, and a requirement in other service systems. Utilization review encompasses a test of appropriateness of the form and level of care. This test is dependent on the rationale of case assessment and on a review of the service tasks undertaken and the progress achieved. A *diligence of effort* requirement in the same legislation is also necessarily linked to the relevance of the service strategies to the assessment, as well as consistency and quality in the services themselves.

The protocols are important as guides to decision-making and service selection in all children's agencies, including those in mental health, mental retardation and developmental disabilities, and family court/correctional systems. Effectiveness in rehabilitative services and in discharge planning is essentially dependent on the range and appropriateness of the helping given the identified needs of child and family.

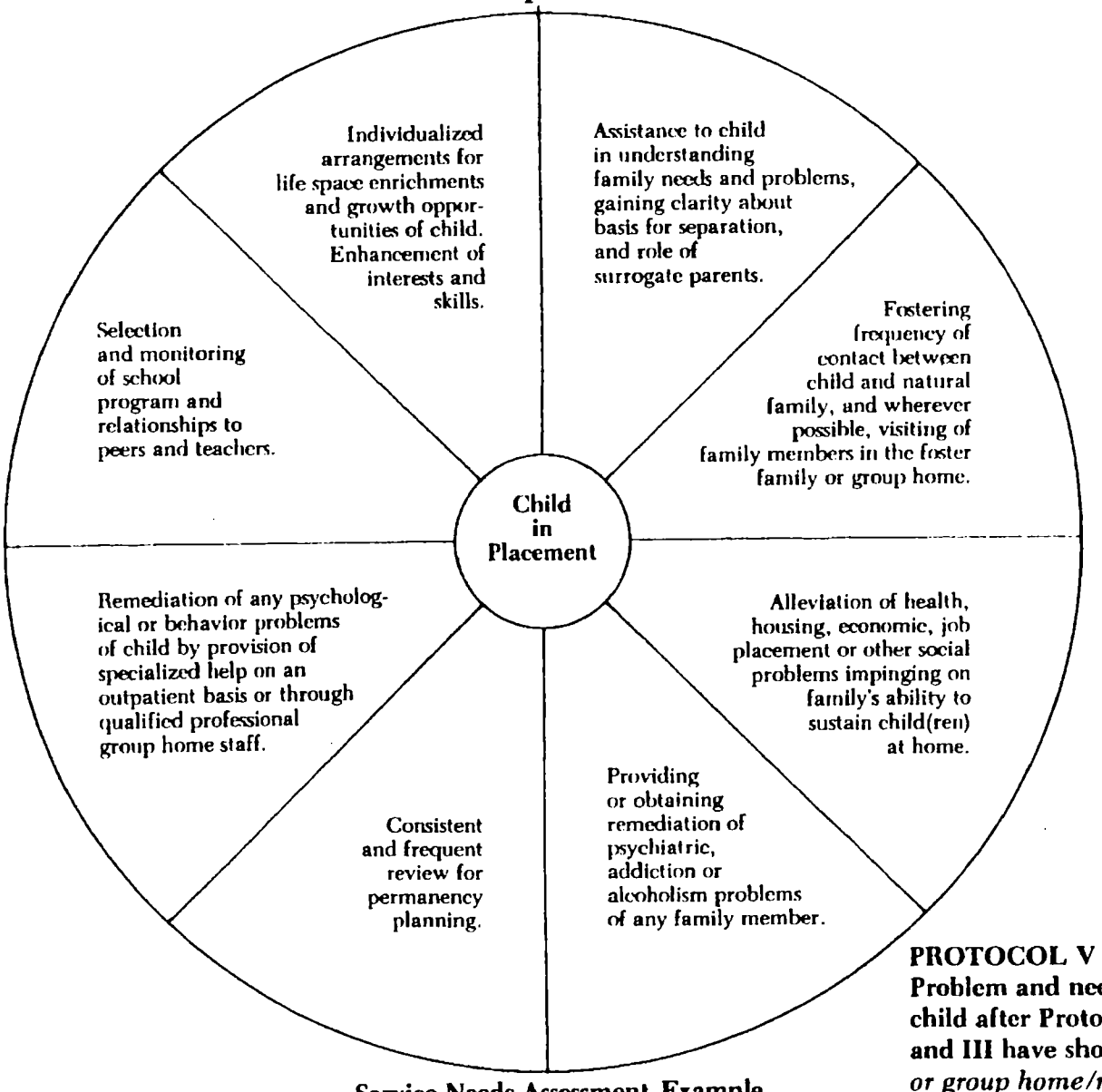
Day Treatment Services for Child



PROTOCOL IV
Selecting options for child in need of day treatment, with *support for family*

Service needs Asessment Example

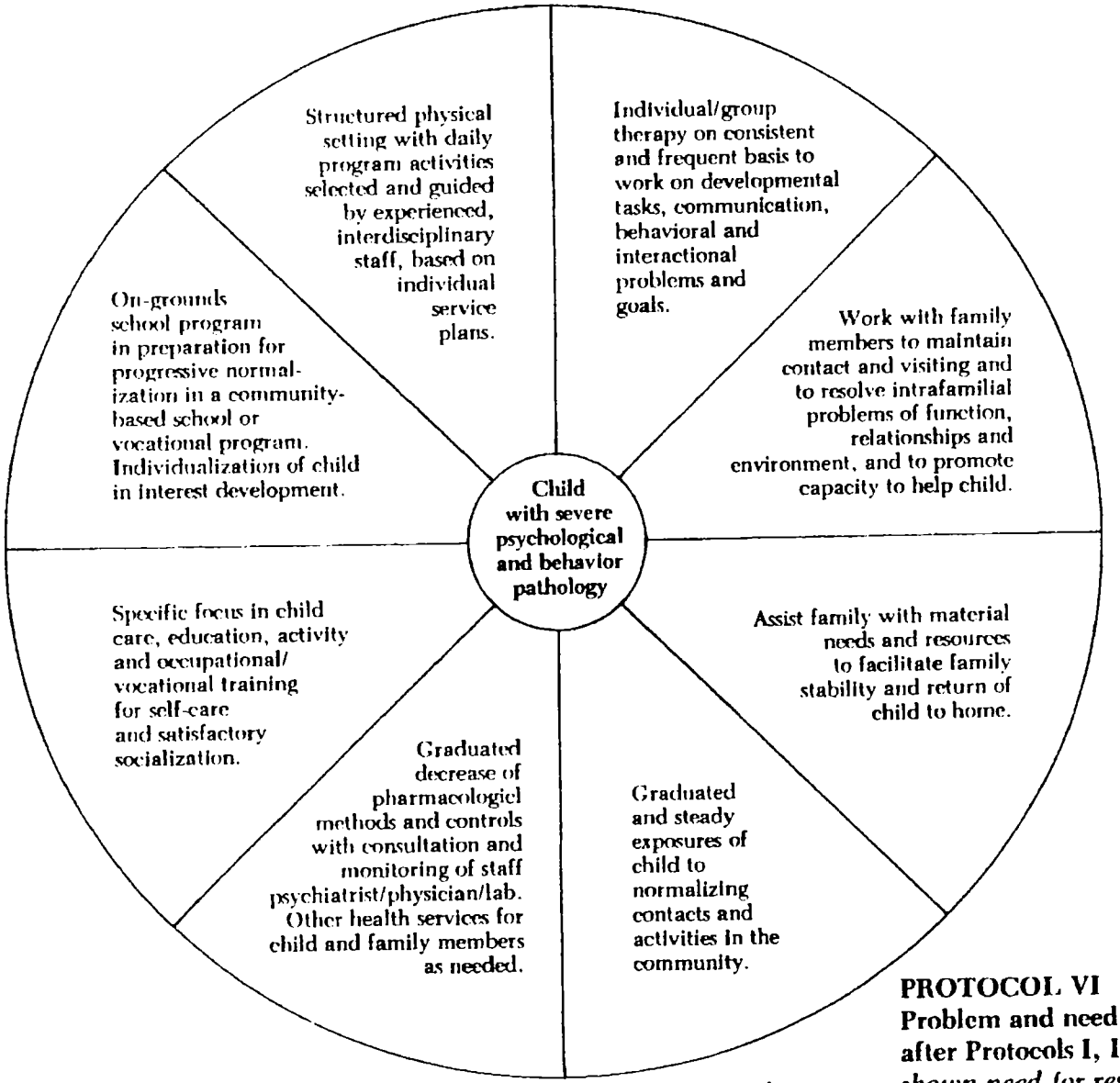
Foster Home/Group Home Placement



PROTOCOL V
Problem and need analysis for child after Protocols I, II and III have shown need for foster hon
or group home/residence placement

Service Needs Assessment Example

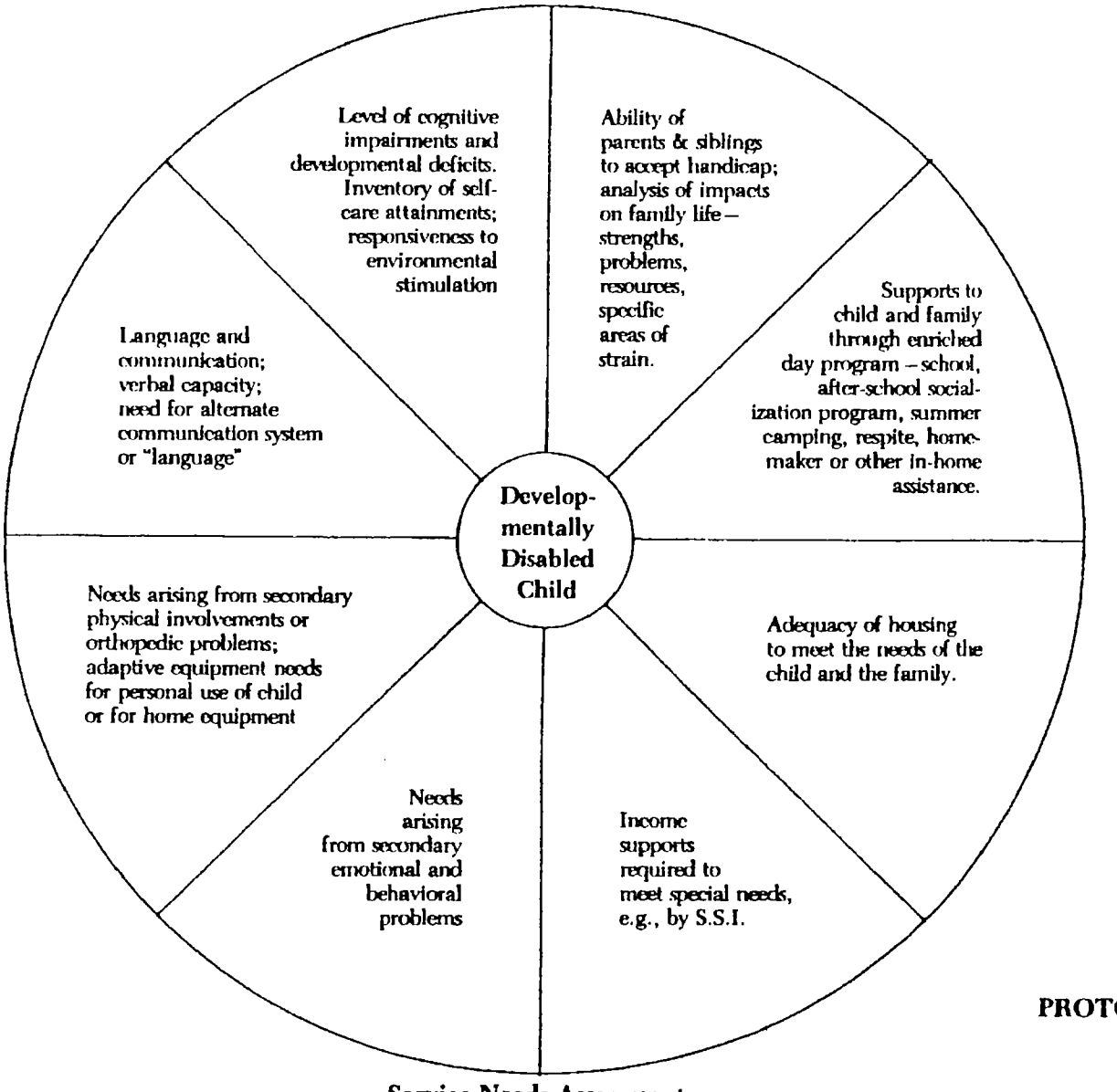
Residential Treatment Program



PROTOCOL VI
Problem and need analysis for child after Protocols I, II, and III have *shown need for residential treatment.*

Service Needs Assessment Example

Choice of Interventions for a Developmentally Disabled Child



Service Needs Assessment

Example B. Mrs. R. seeks placement for her 8-year-old son because of his compulsive stealing which she attributes to his being like his father who has been repeatedly jailed for larceny. The boy is enuretic and on one occasion he set a fire in a wastebasket at school. Twice he was suspended because of fighting, and once he threw a knife at his sister.

An alternate school located in the community where structure, support and individualization are provided five days a week can begin to establish some controls and surcease from the rage and turmoil the youngster manifests, provided that a social worker connected with (or in active communication with) the school can help the mother with her own anger at her husband's desertion, the welfare departments's insensitivity and humiliation of her, her feelings about being locked out of social contacts, etc. This help to the mother can be given with the possible aid of a single parents' group, by providing respite for her so that she can go out once a week and have someone baby-sit with her 8-year old David and younger sister, and/or provide after-school recreation for these children.

Often it is the *range* of supports which determines whether the plan will be appropriate or effective; it is usually more possible to assure this range and comprehensiveness to match multiple needs if the providing social agency is located nearby, offers personal and environmental interventions, and unifies services through a case management design.

Criteria of Appropriateness for the Use of Preventive (Community Support) Services.

While it has been impossible, in the various examples given above, to outline each situation in all its relevant (interactional as well as ecological) dimensions, because of the burdening of space in a document such as this, the reference throughout discussions of decision-making and choice in helping is to concepts of *persons interacting within an environment of impinging systems*. The task of helping involves sensitive recognition of these phenomena, together with a design of service that corrseponds to the level of need experienced by the individual.

It would probably be naive to look for an "appropriate" support service for an alcoholic mother who is neglecting her young children by tracing a list which includes "alcoholism counseling" and then "homemaker", if unsafe housing, insufficient income, need for social group reinforcements, and/or a need for an alternate school for a learning disabled/emotionally troubled child were needs that remained unaddressed. While it is true that some persons, provided with an effective counseling or therapy relationship, may be able to transact other life tasks "on their own", one cannot *assume* that a particular service will carry multiple needs along.

With regard to choices among "preventive" or community-based, family support services, then, it is too limiting to go from a list of options to matched "ap-

propriate" uses as if these were discrete kinds of services or mutually exclusive.[3]

Delineation of criteria for the appropriateness of serving children and families in their own homes is a matter of selecting resources and options based on the configuration of problems, needs and preferences of those to be helped. Appropriateness in the selection of a particular social service agency or program will also include knowledge of the realities of that program operation, e.g., the quality of its staffing, whether there is flexible combination of methods utilized, its correspondence with least labeling, least restrictive but effective service, sufficiency of linkages in a case management framework, ability to carry on case and policy advocacy in support of client needs and goals, etc.

Because of the very wide range that can be seen in personal and social needs of individuals and families, there is, understandably, an extremely long list of programs and services that might be termed "preventive" or "supportive". Some are, specifically, personal social services; others are social provisions in the areas of housing, employment, education, religion, medicine, etc. For the purposes of guidelines in the use of selected personal social services and social supports commonly needed as alternatives to foster care, the following abbreviated list of resources to maintain children with their families, is presented.

1. *Comprehensive, Family-Centered Service Centers.* These may be called by various other titles, including "family counseling agency", "community mental health center", or "multi-service center", etc. These are programs which combine psychologically-oriented service (individual, group and/or family counseling) with environmental interventions and/or socialization activities. Some add tutoring, family life education, etc. Among the services included in these centers (of which there are some variations in models), one might find

   individual, group and family therapy
   women's groups, parent discussion groups
   parent-teen discussion groups
   teen "rap" sessions or discussion groups
   family life education programs, seminars, workshops
   tutoring, remedial, education, or play programs
   speech and reading clinics
   educational and/or legal advocacy
   activity groups and social events
   psychiatric and psychological evaluation; and/or
   emergency residence arrangements either directly provided or by linkage,

3. Recent attempts to tidy criteria of appropriateness by setting up schematic listings of program services and conditions making them, discretely, "appropriate if . . ." "but inappropriate if . . ." are particularly susceptible to what has been called "the fallacy of misplaced concreteness". For example, one research proposal juxtaposed the use of comprehensive family-centered services to day treatment, when, of course, one might include the other or be used side-by-side for particular family members. Recently another research propsosal linked a comprehensive family center to families which had multiple problems, rather than seeing that one or more needs could be brought to such a program!

as well as advocacy for a variety of other helps with financial, legal, employment and housing assistance, etc.

Centers such as described here are rather unevenly distributed but tend to be located in urban areas. They offer many advantages because of the range of methods and approaches they include, their ability to serve more than one member of a family, a variety of needs whether limited or complex, and by short-term or long term involvement.

Whether these centers are following a "community mental health" or "social service" model, they have much to offer children at risk for separation from parents, as well as the parents themselves, as they are generally oriented to social supports and use of resources. They are a preferred option where problems are multi-dimensional: personal, interpersonal and ecological; they are very appropriate for use wherever "preventive" services are sought.

2. *Casework Agencies.* Unlike the centers mentioned above, there are casework agencies which are less frequently restricted to a catchment area. Their scope varies, but usually "casework" (i.e., individual, group and family counseling or social work practice) is an umbrella for direct help as well as linkages with services needed. Some casework agencies allow home visits, but generally they cover a wide area. These agencies range in specialist or generalist orientations and they vary in the degree they go beyond casework to active systems intervention. Families and children most likely to be helped by casework agencies are those who are, in the main, able to keep office appointments. They are often appropriate when parents are the primary clients and can sustain their children when they themselves are given strategic, focused help. Since some agencies are linked with homemaker serviec, day care, etc., within a federation or affiliation, the range of helps may be larger in some instances. Referrals to a particular organization should be based (as with referrals anywhere) on inquiry as to the tasks they take on.

3. *Child Guidance Clinics.* These are generally under the auspices of a mental health agency, a hospital or a university, with mental health and third-party funding (insurances and medicaid). They are often quite similar to casework agencies. Some are side-by-side with another "mental health" clinic in which an adult is client, whereas the child guidance clinic serves children/adolescents as primary clients and their parents as "needed". Some clinics have restricted geographical coverage; some take on more environmental intervention and advocacy than others; some house speech and reading clinics for children. Many of them conduct their work through office visits rather than work in the homes or neighborhoods. In most instances they would be less appropriate for street-wise or more seriously acting-out adolescents. Where parent-child relationships are apparently the main area of problem, such clinics can be helpful in providing assessment, including psychological and psychiatric evaluations in some instances.

4. *Homemaker Services.* A homemaker can be the appropriate service for a mother unable to assume sufficient parental responsibility because of physical or mental

illness, convalescence from such illness, poor preparation for parenthood, emotional or intellectual deficits which limit capability, or acute stress reactions to the loss of a mate or other important family figure. A homemaker may take the responsibiltiy of home management and child care for part of the day in a one-parent home in which the only parent available is the wage-earner; a homemaker may augment parental functions when children are living with an elderly or physically unwell relative, e.g., a grandparent. A homemaker, with some special training, may be able to relieve stress that differentially affects a particular troubled or handicapped heild, e.g., a retarded youngster or one with orthopedic problems, etc., by assuming shared tasks with the parent.

Rarely would it be appropriate to use homemaker service as a chief resource in direct treatment of an emotionally disturbed child, unless the person were given special training. Homemaker service can support a plan of direct treatment by a professional person or agency, however, so that a consistent, stable and caring environment is at the service of the child and parent. Homemaker services may be planned at different levels of service and time involvement: it may be for some hours a day where home management impairment is modest and there is some contribution form parent(s), a relative, or older children. Day or night homemakers can be appointed according to specific needs, or 24-hour homemaker service may be used in a crisis such as a parent's hospitalization or temporary incapacity.

The criteria for the use of homemaker service are its relevance to a casework plan for general family support, a careful delineation of tasks, and availability of supervision and review. The effectiveness of the service most often depends on the homemaker's skill and training, the support given by the provider agency and a good case management plan, and the commitment of the family members to use the help.

5. *Home Health Aide/Home Attendant Services.* These in-home services, in some ways analagous to that of the homemaker in giving support to a parent or other family member, are centered on relieving needs that are medical or physical. These services can be particularly valuable also in enabling a family to care for a physically handicapped child, an autistic child, or a person with special home management needs. Training to the aide or attendant, along with supervision by a worker responsible for case management, are needed for effectiveness.

6. *Day Care.* Day care to support developmental goals for a child or children, and/or to assist a parent in caretaking responsibilities which are taxed in some way, may be in one of several forms:

   In-home care with an adult who is not the parent;

   home-start programs which operate through visits by volunteers and professionals who consult on child-rearing and offer some enabling help in the home;

   family day care in the home of an adult or family who would have responsibility for 2-6 children including children belonging to the home;

family group day care in which more than one caregiver share space and responsibility for 7-12 children; and

day care as well as Head Start center, in facilities equipped for larger numbers of children and a varying range of developmental and educational program activities, as well as some supports for parents in some instances.

In-home day care is more particularly appropriate for infants under two-to-three who can profit from the mroe continuous, individual relationship. Other very young children with special physical needs may profit from in-home day care. Children whose own homes do not have adequate play space or access to play companions or other aids to development, but who are too young for group experiences, may have an enriched experience through family day care.

Home-start services may serve similar groups of young children, or handicapped children, where a parent needs guidance and relief from stress, or parents living in poverty who could profit from help on how to meet the developmental needs of young children.

The use of in-home services would be inappropriate (insufficient) if children with particular handicaps (developmental and/or physical) needed an active sensory-motor stimulation program on an intensive basis which could be better provided in a day program outside the home. See below for further discussion of the models of service for handicapped children.

Family day care offers less specialized or professionalized service to children than group day care, but may be important to a mother who is employed or ill, and who seeks a neighborhood resource. Separation difficulties for the child may be ameliorated by family care arrangements as contrasted with group care, especially if the child is not ready for group play. Signals of distress on the part of a child when placed in a group setting, such as feeding difficulties, excessive crying, withdrawal or sleep disturbances, should be heeded, and there should be observation of a child's tolerance for a group setting.

Group day care, in family homes and in centers, offers possibilities for more comprehensive developmental and educational services, although not all group day care centers and arrangements have such enrichments. The use of group day care should be preceded by study of the particular program to see how it meets the objectives of promoting cognitive and physical skills, skills in relationships, and linkages on behalf of families.

7. *Day Treatment Centers.* While most day care facilities are either neighborhood-based or designated for a particular local population of pre-school children, day treatment centers follow one of several models:

for pre-school aged children they would be specialized for such groups as cerebral-palsied, neurologically or orthopedically impaired, or developmentally disabled or retarded children who have need of physiotherapy and other sensory-motor stimulation programs, programs for ambulation, and other particular needs;

for school-aged children there are centers for similar groups of handicapped youngsters in which therapies are provided along with educational components; there are also day treatment centers for emotionally disturbed children in which individual and group therapies are combined with schooling, and some such programs for autistic children;

some day treatment programs are particularly designed to meet the needs of learning disabled, acting-out, or behaviorally disturbed adolescents, in which they work on remediation, amelioration of alienation, developing social competence, vocational preparation, and/or the shaping of new behaviors.

Some day treatment centers are attached to mental health agencies; others are programs sponsored by agencies in the mental retardation/cerebral palsy/epilepsy and neurological impairments fields of service; others are programs sponsored by child welfare/social service organizations; still others are part of BOCES services in some counties. In programs where there are multiple services of a medical/clinical/rehabilitative nature along with education, the educational component may be supplied by the same agency or by the local public education department.

Day treatment centers vary in their supports or outreach to families and siblings, as well as in their own program strategies and activities. Generally, day treatment tends to be more child-focused than family-focused as the child is the primary client and the recipient of the basic agency services. Because of the amount of "life space" affected in a program providing therapeutic management and services over five days a week, day treatment can be a very important resource for children and adolescents with quite serious needs.

Day treatment should be considered for appropriateness before recourse is had to residential care or hospitalization, particularly if the family is able to maintain a child at home with this and any other needed supports. Day treatment would be inappropriate (insufficient) if by reason of psychiatric illness a child were dangerous to himself/herself or others, or this risk to self or others were caused by a deep-seated behavioral disorder or alienation.

Children already in foster family or group homes may, in some instances, need the additional support of a day treatment program along one of the above models, depending on needs, for the remediation of developmental, emotional or behavior problems, as an alternative to more restrictive forms of residential care or institutionalization.

Day treatment is also appropriate for some children following hospitalization or discharge form residential treatment, for transitional help as well as maintenance.

8. *Alternate Schools and Special Eduational Programs.* Within the public school system, and also in certain subsidized non-profit or proprietary systems, special education programs can be found for children with a variety of handicapping

conditions – physical, intellectual, developmental, emotional or behavioral. More favorable teacher-student ratios, individualized curricula, selected content for competence building, and certain clinical support services may be found in these settings, which do vary considerably in quality and focus.

With careful exploration of the design and staffing of these special programs in relation to the particular needs of children, they can be very valuable in the relief of stress and promoting positive functioning.

9. *After-School Recreation Centers.* These are more likely to be neighborhood-based or in local youth centers or settlement houses, and some are affiliated with churches. They are useful for school-aged children and adolescents in a variety of needs for preventive and therapeutic management. They help to provide shared social experiences, task organization, project participation, skill development, and relatedness to a larger community. They are in some instances, with good leadership, channels of social control for children who lack adequate supervision/discipline at home or who are inclined to less impulse control. They can augment social exposures which a parent might not be able to provide. They are able to bring adult role models into relationship with young people. Children from crowded or tense homes may profit from the physical and psychological "space" at such centers and the activity outlets they permit.

10. *Drug Abuse, Alcohol Abuse and Other Rehabilitation Programs.* Some of these are day treatment kinds of programs, some more like outpatient clinics, and some offer emergency or crisis help including short-term residence or detoxification.

    While there is a clearer indication of the "appropriateness" criterion for detoxification, i.e., actual addiction, value and judgment enter much more into the selection of treatment facilites for the alcohol or substance abuser. Methadone maintenance is usually medically and psychologically disapproved for young people under 16. The use of certain "therapeutic community" programs for children and adolescents needs to be carefully weighed, wtih exploration of the strategies and tasks they select, especiallly where these centers regulate or control contact with family members. Psychological harm is possible, in some situations, when youngsters of fragile ego organization are treated by confrontation and other "group therapies" which they cannot tolerate or absorb. In other instances, youngsters inclined to conflicts about dominance or submission may "identify with the aggressor" in accepting harsher controls and direction. Alcohol users and their families can be served by, or with the help of, Alcoholics Anonymous and Alateen, as well as by special alcoholism treatment projects in hospitals and community mental health centers.

    Holistic assessment of the child and family should form the basis for selection of services, with the guidance of skilled professionals in these special areas.

11. *Other Important Resources.* In most counties and urban areas one can find resource directories that contain a large variety of services and provisions not included in any of the headings above. In large cities there are regional or district

directories. So numerous are the listed services in some instances that they occupy volumes; in other cases there is a movement to computerization of resources in order to retrieve information about them!

Space in this document does not permit even a thorough categorical list of such services, but a suggestive outline is given to urge social service personnel and planners to search out those possiblities which can be of critical value in the formulation of a "service plan", particularly in working with children and families at risk.

Many of these resources become attached to very specialized associations, organizations or service groups in fields of concern such as:

physical/medical problems and their social and emotional consequences: for example,

diabetes;
cancer, hemophilia;
orthopedic problems;
multiple sclerosis, muscular dystrophy;
ileitis and colitis;
blindness, deafness;
epilepsy, neurological disorders;
cerebral palsy, and so on.

There are resources attached to special statuses such as ex-offender, involvement in the juvenile or criminal justice system, ex-psychiatric patients, single parent status, runaways, teenage pregnancy, displaced homemaker status, and others relating to many other kinds of categorical funding systems which are attached to the "problem" area. Some programs of counseling and other services are reserved for "court-related" or "diversion" purposes. Some are attached to families where there has been intrafamilial violence, some just to "battered wives". There are some shelters for such abused women who have been beaten by their husbands, and some for women who have been raped. There are services reserved to the members of particular labor unions and their families. There are "mediation" programs for families involving a PINS child, and other programs specifically for parents abusing children. And in the areas of "child abuse" services, there are now separate or special programs for cases involving sexual abuse of children. Some programs have recently emerged for school dropouts, for truants, and for "latch-key" children who have no supervision after school while awaiting the return of the parent wage-earner. Some "mental health" programs specialize in marital counseling; some organizations serve the woman prisoner. Some pastoral counseling groups serve couples and individuals having "mental health" concerns, etc.

The list of specializations is actually too long to give.

As well, there are a whole host of old and new self-help groups and mutual aid projects, as for example:

Parents Anonymous;
Alcoholics Anonymous;
Food Coops;
Big Brother-Big Sister Projects;
Junior League Projects;
Volunteer Projects attached to family courts, to community agencies, to schools;
Prison visiting associations;
Church-related recreational and social activities; church "outreach" services;
Credit unions;
Fresh Air Fund and Vacation/Camping Offerings;
Single parent Groups; Black Single Mothers Groups;
Foster Grandparents; Senior Citizen Volunteers;
Meals-on-Wheels/Youth Services Teams;
Block Associations; Baby-Sitting Exchanges;
Day Care Coops, and so on.

and then there are a variety of services attached to special systems such as public housing projects (these can be inclusive of personal social services and counseling), or to public schools, such as guidance help, psychological screening, or after-school recreational centers. some educational systems include part-time work experiences, vocational preparation of the handicapped, etc.

Recapitulating this discussion of options in the selection of resources which may constitute "preventive services" or supports to children and families at risk of separation, one of the problems to be encountered may be this very multiplicity of resources, in some instances over-specialized in central locations; in other instances attached to a special problem category; and in still other instances, so informally designed that they are less known and less available. Many services which are "targeted" to children and adolescents, while excellent in value, do not comprise help to parents or siblings. Some are limited to personal social services but do not go to the financial assistance, housing, education, employment and legal systems for advocacy, brokering or linkage. Some church-related and strong social supports are not linked with the specializations needed for some handicapped persons. And so, for families and children with serious life management difficulties and multiple-level problems, there can be starvation amidst plenty, given this diffuseness and fragmentation.

It is all the more important that in cases which come to attention because of the risk that children may be separated from their families, the selection and offer of help be relevant to carefully assessed needs, their acceptability to those who would be users of service, and their meaningfulness in a comprehensive and integrated service plan, a plan which can articulate and bring together the interpersonal and ecological dimensions of family-child problems. The span of help offered is critical because simplistic solutions to complex stress life situations fail. Case integration and case management are also as critical, as it is not reasonable to have a [illegible] burden of locating both the basic and specialist

helps from agencies and groups which have inconsistent access requirements, goals and objectives.

The "packaging" of services at the neighborhood (local) level in comprehensive personal social service centers where the helping includes advocacy and brokering as well as sustained, direct services for as long as needed, has much to offer. It is at the local level that the impinging systems affecting the lives of children can be drawn together. Generic social services, community-based support, and timely response systems to family and children's needs within agencies, schools, medical institutions, welfare centers, churches, youth centers, housing groups, employment programs, police and courts, are the fundamental content of "prevention". The multiplication of categorically funded programs deserves caution and monitoring, while specialized programs which are enriching will certainly be needed.

The Creative Use of Community Resources.

While there would be many who claim that existing personal social services and social supports are under-utilized, it is inevitable that they appear to be unavailable or exhausted in numerous other situations confronting those at "intake" desks and those trying to accomplish an appropriate service plan. Workers are often called on to create the resources they need, especially in encouragement of their agencies to support the networking of community groups, volunteer projects, and self-help associations where there is a trading off of experience, knowledge and learned skills. Workers can be creative too in serving as catalysts for the input of persons from other helping systems, such as public health, child development centers attached to universities which might provide internships, arts and cultural centers, corporate business firms' public affairs departments which can provide direct and indirect services, and fraternal organizations. There is often a need to "call in" the resources of large, county-wide or city-wide organizations so that there is a contribution at a particularly local level, or an "adoption" of a project in a neighborhood or community. The development of community education projects by getting voluntary contributions from public and voluntary agencies, particularly the specialized ones which can address information needs in a community, can be very helpful. Informal resources can be developed for respite care in homes where there are handicapped children and whose parents need relief. Interfaith clergy associations may help in the "staffing" of self-help groups, or in such a project as a "safe homes" project for battered women.

Other new resource developments can occur by working at the point of "interface" between two human service systems, e.g., schools and the health system or hospital; or the family and the school; or the police and the youth gang systems. In the future the "community school" model of services, in which a variety of community groups participate in a range of programmatic services – social, recreational, family education, child development education, etc., will be a promising way of maximizing this principle of interface in building the capacity of a com-

munity to sustain children and families. Space here does not permit more discussion on "community development" activities as new resource development.

Supportive Services on Behalf of Adolescents

Problems in the rearing of adolescents, as well as in the "delivery" of services to them, constitute a very large professional literature as well as discussions in living rooms and conference halls. Small wonder that when social planners or agency administrators project program needs in "child welfare" and "youth services", they study census and demographic data for the peak periods of adolescents in the population.

While adolescent turmoil is normally explained in biological, physiological, psychodynamic and sociological terms, relatively few service programs take adequate account of these developmental forces in the way they shape their tasks and activities. Again, for the sake of guidelines in devising supports for adolescents and their families, holistic assessment is urged. One needs to attend to all the dimensions of need and growth mentioned above. They are closely interrelated. The assessment should systematically encompass the youngster's developmental history, relationships within the family, socialization and learning experiences, and the social systems which have impinged on all of these.

There is a particular need to supply such assessments at a time when adolescents in increasing numbers are finding their way into foster care – into group care and institutions, particularly. Informal reporting from staff of hospitals and runaway centers, as well as correctional facilities for youth, shows that some of these youngsters make their way from one program to another. There is a special need to shape services so that they address the emancipation strivings of adolescents without minimizing how "attached" these young people can be to their parents and to others in their environment, either positively or negatively. Programs which work with adolescents with little or no contact maintained with families and "environment" may miss the mark. There may be considerable naivete in programs which "treat" adolescents outside the context of family and reference groups because of the deep salience which these social systems have for identity. Ego development in adolescence is supported as we find ways of engaging energies toward effectance, skill building, socially rewarded tasks, and affirming social experiences. Fortunately, there is a wide range of modalities to be called upon within and by community-based organizations, youth service groups, schools and project-oriented centers. Certain youth service bureaus, school-based recreation and work programs and youth leadership initiatives can "employ" the energies of adolescents in valuable ways. Very often even rebellious adolescents *need* their parents and siblings or at least need helpers to take their families into account. The proverbial alienation of adolescents from parents and family members is often superficial, and apart from the occasional formulation that "I want nothing to do with my family," a runaway or even delinquent teenager frequently welcomes interventions on

Social supports in many instances are the very substance of a desirable therapeutic plan. At the least they are ordinarily required as part of such a plan. The use of social supports is particularly relevant in how we "think" about preventive services for adolescents at risk of placement.

Services to Children and Families through Foster Care Placement

The placement of children in substitute care, when legitimated by the holistic assessment which has been insisted on throughout this document, requires some additional considerations and decisions. The choice of the placement resource should never be random (or made through a routinized "allocation" office of a centralized public agency which has no direct, personal knowledge of the child and family. Choice is essentially tied to careful, individualized preparation of child and family, as well as selection of resources. Placement which occurs in life-threatening emergencies or crises should be in a designated "study home" (a family home or group home/residence) which permits the completion of a full study of the needs of the child and family as well as the forces which have impacted on them. Such placements should be protected by strict time limits. Respect for the importance of *knowing* the needs of the individuals involved, together with provision of a skilled team to accomplish the study, make a thirty-day assessment period a reasonable time limit. While a child is in this kind of temporary care, the provider agency, whether public or voluntary, should keep the assessment activities going with uninterrupted pace, and with the coordination of any organizational units which are party to the "case" situation, e.g., foster care and protective services units within the public agency, or between these and the family court, etc.[4]

Since there is often some difficulty in reversing restrictive placements (as well as reducing the trauma experienced by children sent to such facilities), it is inappropriate to place children into institutional programs for temporary care, unless there is particular reason to utilize a special diagnostic unit or center; more on this below. An emergency foster family home network should be maintained by the public child welfare agency, either under its own aegis or by contract with voluntary child welfare agencies. These emergency homes are appropriate for children and adolescents of all ages, so long as the caretakers have appropriate qualifications and training as well as the staff support of the sponsoring agency.

Group homes and group residences which are specially staffed as "diagnostic centers" can also be appropriately used in situations of crisis where intensive exploration and assessment need to be undertaken, using an interdisciplinary staff on site or attached to the program. Preferably these programs should be locally based and accessible to the families of the children who may be in residence for the brief period of assessment. Exceptionally, diagnositc units or "centers" which are part of

4. Small caseloads, necessary to lead and manage holistic case assessments within rigorous time limits as recommended here, will be economic by their function of facilitating decision-making earlier and avoiding "drift" in the entire process.

larger institutions or hospitals might be appropriate for youngsters in which there is a need to call on very highly specialized services not otherwise availble.[5] In complex situations where there are strident interpersonal dynamics involved or very disturbed behavior by a latency-aged or adolescent youngster, the very process of a thorough assessment and involvement of the individuals with an interdisciplinary staff can be fruitful in clarifying their issues and needs as well as developing a new equilibrium. Here again the use of strict time limits is essential. The need to plan within a specified time frame (thirty days, ideally; six weeks at maximum) is a form of call to responsibility for all the parties involved. Within a suitably staffed diagnostic group care setting one is apt to find services which include social work, psychological and psychiatric, medical and educational assessment accomplished by a staff who can integrate their observations with each other and with the child and family in order to understand a direction for help with personal and environmental needs. In some situations the controls of a therapeutic milieu make it possible to sort out the various personality, familial and environmental strains which may not have been recognized or handled when a crisis erupted. Consideration of options for problem resolution or the reduction of strain may also be the subject of planning during this temporary residential stay. In order to accomplish these tasks, the study homes (family or group care settings) need to be within easy access of families and those social systems and resources which can be called upon in the service plan developed with parents and children.

Study homes for children of pre-school age should always be in family settings, except where medical or developmental problems of an exceptional nature require assessment in a hospital, e.g., victims of serious child abuse or neglect.

Beyond the Study Stage: Choosing the Foster Care Resource.

A decision that a given child's physical, social and/or emotional needs cannot be met within his/her family even with social, personal supports and environmental changes offered, requires further discriminating choices to be made in the selection of a new home for the child. Those choices will be guided by the following kinds of considerations in order to assure appropriateness:

1. The relationship of the placement to be made to a specific plan of permanence. The latter (which will fall into one of the broader boundaries such as reunification of the child with parent(s), or adoption, or – in the case of an adolescent in some situations – preparation for independent living) will be spelled out on the basis of the comprehensive assessment of problems, needs and resources described in this document. The assessment base will be used to delineate time frames for the projected placement.

5. Examples of such needs might be in relation to a youngster who has shown strong suicidal ideation or made a suicidal attempt, or a youngster whose assaultive behavior could not be managed in a community-based group home/resistance and who needs evaluation as well as help to find appropriate, continued services.

2. A showing of how the choice of placement will be a *part* of a total service plan encompassing the child and his/her family.

   With regard to the child, there should be a matching of a foster family home, foster child and natural family with regard to race, ethnicity and religion, in order to protect ego identity needs. The stated plan of permanence also requires the consistency of specific services to parent/family members needed to accomplish their respective roles and tasks.

3. A showing of how the *location* of the foster care resource will facilitate the accomplishment of the plan of permanence. For example, where reunification with the family is the goal intended, proximity of the foster home (family or group setting) for easy and frequent visiting by parent(s) and child(ren) is very important. Ethnic, racial, religious and social compatability also become more feasible when geographical proximity is taken into account in the choice of placement. Such proximity is not as relevant in cases where it is clear that adoption will be the ultimate plan. The relative value of a kinship foster home toward the accomplishment of any of the kinds of planning for permanence cited above, would also interact with the question of geographical proximity.

4. Discriminating understanding of what familial, emotional, social and educational values or advantages may accrue to adolescents being considered for placement either near their own families or at a distance; more on this below.

5. Consideration of special characteristics and/or service needs of the child(ren) to be placed, for a showing of how a prospective placement (and the supports to be garnered in that setting, by the caretakers, and/or by the sponsoring agency and community) can best suit those needs.

6. A showing of how the service plan, while providing levels of service appropriate to the needs of the child(ren) and family members, protects the principle of least restrictive alternative as well as all possible avoidance of negative labeling and social stigma. This showing will necessarily be based on a careful study of options and resources which can be called upon.

7. The "track record" of the caretaker (agency, program, and/or individual provider) for high quality of care and ability to pursue the developmental, familial and environmental needs of their clients.

Consistency of the service plan with the needs assessment made in each case, as emphasized earlier in this document, is put to the test in all the above dimensions of choice. Criteria of appropriateness are actually satisfied when we know enough about the problems, needs and resources of the child and family and the social systems impacting on their situation, so that the service response and options selected (with fullest possible involvement of child and family) are congruent.

It is only with these principles set in focus that one can go on to examine the relative functions of certain *forms* of placement, from family types to specialized institutions. The forms themselves do have meaning for those who engage in the

selecting and decision-making, and they have important implications for public policy and program development in child welfare as well as the other human services.[6]

Because it is common in child welfare, mental retardation, mental health and youth service systems led by government to classify services along the continuum of family homes through a variety of group care arrangements and/or institutions (with some of this classification based on facility *size* factors), the following outline of the forms of substitute home care will remain in some correspondence with such classifications. However, the boundaries among these are sometimes more nuanced by definitions given in governmental regulations (definitions sometimes based on the size of the facility or population capacity) and funding sources than they are by discrete service composition. The usual forms of foster care, with general principles guiding their selection are:

1. *Foster Family Homes.* Ordinarily, because of the advantages of normalization and availability of primary relationships within a family context, foster family homes are considered to be a first order of option of children who cannot be sustained in their own family homes. Foster family care is the only appropriate kind of care for infants and pre-school aged children; it is also appropriate for many latency-aged and adolescent youngsters depending on their characteristics and needs and the adequacy of the service plan as a whole as listed on pages 54-55 above. Foster family care can also be helpful for some children with special needs who are ready to leave a psychiatric hospital, residential treatment center or other institutional facility. Children who should not be in foster homes are those who refuse to accept substitute parents and reject living with a substitute family, children who are of danger to themselves or others, youngsters who cannot find acceptance in or adjust to a community school, or children who because of fragile ego development and/or extreme impulsivity need a more structured type of setting and program with some amount of peer and adult role modeling and on-site professional help. There are some latency-aged or adolescent youngsters who appear to have not much "glue" with which to organize behavior and activity and who need supervision and more professional help than is available in a family setting. Adolescents who are particularly rebellious, who have repeatedly run away, and/or who have strong hedonistic tendencies and resistance to adult authority, may also not be appropriately placed in foster homes. However, it is sometimes possible to sustain children with special problems or handicaps when foster home care is joined to other supports, e.g., a day treatment center which could provide special education as well as individual counseling or therapy. Alternate educational programs, medical services in or near the foster home by a visiting nurse or

6. In the 1975 monograph by this author, supra, the primary purpose was an analysis of criteria of appropriateness in the choice of the form of placement itself, since material was to be used in a survey of children already in placement in one or another kind of foster care. Allusions were frequently made to assessment factors to be found in "typical" situations or examples, although the scope of that work did not include a conceptual framework and methodology for the assessment and service planning as here presented.

clinic, after-school recreational programs, and a variety of forms of counseling or therapy are some of the most frequently used community supports which may make it possible for a foster family to sustain a child with particular needs. Provision for the foster parent to have ongoing consultation with a child care specialist, an experienced social worker, a psychologist or psychiatrist, may also enable such a foster parent to deal with special tasks. The kinds of help given to the foster parent to relate to the child's natural parents and siblings (as well as the child's own feelings and experiences in relation to family) may make a difference in capacity to sustain the youngster "in care". Matching child and foster family inevitably means taking into consideration the motivations, characteristics, and personality of each individual. For example, a foster mother might do well with infants and young children, but because of serious deprivations or estrangement in her own adolescence she may find it more difficult to be a foster parent to an adolescent. In a rural area, where proximity to organized recreation, social supports, day treatment or other services may not exist, the adequacy of a foster home for older children and adolescents with disabilities or handicaps may be much less, whereas youngsters with simliar characteristics could be helped in a foster home linked to such resources.

Types of foster family homes include:

(a) *Foster boarding homes.* These are homes belonging to persons who are licensed by a public or voluntary child welfare agency to care for a child or a specified number of children, under conditions and regulations governing the quality and range of that care. These homes are under the continuing supervision of the sponsoring agency, and the latter makes payments to the foster parent(s) for the care and special needs of the foster parent(s) for the care and special needs of the child(ren). The number of children who may be cared for in a particular family home will depend on the characteristics of the caretakers, physical space available, number of own children, experience in foster parenting and other such factors. An entire sibling group may go into a foster boarding home. When there are several unrelated children in a single home, it would be less advisable for an infant to be included with older children/adolescents because of too wide a range of service needs. However, as mentioned above, infants and pre-school aged children should always be in foster family homes when they need to be placed.

(b) *Agency-operated boarding homes.* These are group foster homes for which a larger range of operating costs and expenses of the home are paid for by the sponsoring agency; the latter in turn would be reimbursed according to rates set by the public child welfare agency. The aim is to maintain a family atmosphere similar to that in a foster boarding home, although the agency-operated boarding home will in some respects resemble a small group home. Agency-operated boarding homes are sometimes ideal for a sibling group, or for a group of children/adolescents having some commonality of service needs which would make a "peer group" of some value in providing services and linkages with community resources. In some instances the actual home site for this kind of family boarding home is rented and/or furnished by the sponsoring agency in order to

give the caretakers the facility to provide for a group of children. The home site may be a detached dwelling or apartment. Group boarding homes should not be used for infants unless one were part of a sibling group. Agency-operated boarding homes are appropriate for those children who can use a foster family setting shared with other youngsters, i.e., those who meet the general criteria described for foster family care and who are placed with caretakers able to participate in a holistic service plan for their social, emotional and educational development.

(c) *Free homes.* Foster parents offering a free home do not receive payment from a social agency but agree to that agency's review and supervision for a child usually known to them by a relationship occurring prior to the placement. Sometimes such a home is offered by a neighbor, parents of a child's playmate or schoolmate, or a relative. (Relatives, however, may also be licensed as foster parents and reimbursed for the care of the child[ren] placed with them, if this is mutually agreed upon between them and the authorizing child welfare agency or family court.) With careful screening for the qualifications of caretakers and the quality of care to be provided, the age of the child placed would not be controlling as such a "free home" could be suitable for a child from infancy through adolescence. However, a full case assessment as well as exploration of the proposed caretaker(s) situation and motivations would be necessary before use is made. The economy of this option should not be controlling.

(d) *Wage-work homes.* These are homes in which an adolescent is accepted for family care in return for some personal services such as some baby-sitting, help with housework, or "mother's helper" role. Although such planning also has to be made very cautiously and with full assessment in regard to all the parties to the arrangement, because of the risks of exploitation or neglect of some basic developmental/social/educational needs, certain adolescents who need to emancipate themselves and who are able to handle themselves in a community, have profited from this type of foster care. Those who are considered for such wage-work homes should be sixteen years of age or older and should normally be involved in a school or vocational training program at least part-time while living in the home. Youngsters who are emotionally disturbed, who are in danger to themselves or others, who need the patterning of a more structured or professionalized setting, or a closer link to a supervising child welfare agency and a particular plan of of permanence, or who are vulnerable to exploitation because of mental retardation or other handicaps, should not be placed in wage-work homes. Caretakers of these homes should enter into an agreement with an authorized child welfare agency or court for the review of the youngster's needs and ongoing planning.

2. *Group Residential Care.* The various forms of group residential care are almost always administered directly by a social agency and that agency's employees, whereas foster boarding home care is generally purchased from families who use their own homes or occupy a home site provided by the agency.[7] Group care settings vary in their approximations to family style living. There are some group homes in detached dwellings or apartment settings where group home "parents" or counselors act as surrogate parents and live in part or all of the week.

7. In recent years there have been a few "youth-run" residences.

At the other end of the continuum of group residential care, i.e., in institutions, caretaking may be the responsibility of three shifts of staff who cover a 24-hour period along with a variety of other part-time or full-time staff in disciplines such as teaching, recreation, vocational training, social work, psychology, psychiatry, nursing and medicine, and sometimes with in-house chaplains as well. Group care settings incorporate community resources to varying degrees, with some making almost entire reliance on their own services to the children or adolescents in residence. Institutions, whatever their goals for therapeutic management, role modeling and "parenting" responsibilities, least approximate family care, although individual staff members may in some instances be perceived by a youngster as a parental surrogate.

The more usual types of group care are:

(a) *Group homes.* Group homes, like other group care settings described below, are entirely supported by a public or voluntary child care agency under conditions and regulations set forth by a (state) governmental department. These regulations in some ways define the setting in terms of a stated capacity or size factor, i.e., 6-12 children. More often group homes are either for boys or girls, unless they are for large sibling groups; few are otherwise coeducational.

A major consideration in using group homes is their "community base" which contributes to values of normalization of relationships with social, educational, familial, religious and ethnic, and other associations that are part of human development. (Such relationships and access to resources are, of course, part of the normalization assumed to be available in foster family care in any of the forms outlined above, but there are inevitably some variations in how this is assured.) Group homes are normally located in residential areas. However, in some instances the location might be remote from the community in which the child originally lived. Some are in suburban or rural areas in which children need to ride to school, medical facility, recreational resource, church, etc. Still others are "neighborhood-based", i.e., located in the neighborhood from which the children came or close to it, in an urban area.

Group homes are appropriate for school-aged children and youth for whom the very management of their developmental, therapeutic and familial needs, requires access to the supports and resources outlined above.

Children who can profit from group home placement may have affectional ties with their own parents which preclude their acceptance of the more intense emotional involvement of taking on foster parents; or they may be children with special emotional problems or physical/behavioral/learning disabilities which require more professional help than would be available with foster home placement. Older children and adolescents may be found to do better in group homes (or group residences as described below) than in foster homes, in some situations, if they are resistive even with adequate preparation and exposure to options. In this regard it should be noted that for some adolescents who are working with strong needs for emancipation, group home or group residence placement may actually be experienced as a *less restrictive* placement than foster family care

which may be perceived as more controlling and limiting. This would need evaluation in the context of full case assessment also. The location of the home and the characteristics of caretakers and staff will also help to determine the appropriateness of a particular group home for children and youth with observable handicaps and behavioral disturbances which would be manageable by the program and the community in which it is placed. Some group homes have been able to sustain young people with particular kinds of "acting-out" or unconventional behaviors, more than others. Much of this will depend on the capabilities, attitudes and resources of the staff and the supports they can call upon in promiting positive, goal-directed behaviors of the youth; in other instances acceptance of the neighboring community will be determining, e.g., whether homosexual youth or those with other unconventional behaviors will be tolerated and responded to.

In other instances, a group home may be more appropriate than foster family care because of more "troublesome" characteristics of one or both parents of the youngster, which could be better managed by a professional staff attached to the group home. (There is usually, also, a larger number of staff assigned to a group home than one would find in an agency-operated boarding home, for example.) For all the reasons given above, the choice must be governed also by all the relevance it may have to a plan of permanency.

For children who are leaving institutional care of any kind, a group home or group residence may provide more "transitional" help than direct placement in a foster family home, although the amount of preparation for the latter may make it quite feasible and profitable for the youngster.

Special care should be taken to seek a coeducational setting for a youngster with problems of sex identification or active homosexual interests, so that these issues do not become additionally enmeshed in control/dominance/submission dynamics which are sometimes set in motion in group and institutional settings.

(b) *Group Residences.* While the terms "group home" and "group residence" may reflect semantics, they are also usually based on a definition given in governmental regulations based on size factors. While group homes are usually said to be "family like" residences and programs for 6-12 children, the "group residence" so called, is "set" for 13-25 youngsters. Group residences are much less available as an option, as it is sometimes more problematic to find the physical facilities and space for such a number. They are more apt to be available in urban areas and to serve adolescents.

Group homes may be too small to permit (especially because of economic factors) the assignment of a discrete clinical staff on-site, whereas group residences do normally provide for social work and/or other clinical staff to work directly at the facility. Group residences, like the group homes described, are more usually for boys or girls rather than coeducational.

In general, group residences are often appropriate and helpful for the following types of youngsters:

- adolescents who have had disabling emancipatory struggles with own parents or foster parents, and who need more professionally-toned relationships with adult authority figures as well as a positive and supporting peer structure;

- Adolescents returning to the community after institutionalization, with residual problems which require on-site continued professional help;

- adolescents who come from homes where cultural backgrounds and/or a restrictive religious sect or cult may have contributed to acute, intergenerational conflicts or conflicts of recognized norms, so that such youngsters need neutral, supervised settings to test out freedoms and heterosexual friendships;

- adolescents with behavioral and/or emotional problems, or psychological impairments which require help in a therapeutic milieu directed by an interdisciplinary staff – a milieu which is, at the same time, open to frequent transactions with friends, relatives, schools and community social systems and organizations.

- Adolescents who have been drug or alcohol abusers, or repeated runaways, who profit from a group care setting encompassing, along with other therapeutic resources, positive peer pressures as well as individualization of helps and services.

- adolescents who have had a repetitive experience of failure in family type or group homes.

The use of group residences for diagnostic and assessment purposes has already been mentioned.

When an established plan of permanency involves the preparation of an adolescent for independent living, a group residence for some youngsters with characteristics such as those listed above may have value, particularly if the program includes linkages for work experiences, vocational training and/or college placement.

(c) *Institutions.* For a "first cut" at classification, institutions are defined in regulations on the basis of population capacity, i.e., programs which have a residential population of 26 or more. Within these settings there may be some physical divisions, such as separate cottages or "units" which may be apartments set off in a large building or even separate buildings. In institutions where there are these multiple units there are staff who are reserved to work with the children of a discrete grouping. These designated staff may also include social workers, recreation workers, psychologists, psychiatrists and nurses, etc., working in "teams" with the child care workers or counselors. The team assignment is recently becoming governmental recommendation or even regulation, for the sake of individualization of need and effective case management.

Placement in institutional care is to be regarded as a restrictive measure to be called upon when the needs of a child cannot be assured by other forms of care. Institutional placement is *not* determined by family-related characteristics: the use of this service option would always be based on the levels of services required by the youngster him/herself. The justification of institutional placement, then, would require a very special assessment of need, including answers to the question: "What tasks are required to help this youngster which, either could not be achieved in the community, or could be better achieved in an institution than elsewhere?"

Although it is the child's special problems and needs which would constitute the rationale for this kind of placement, it is very important to examine the presenting behavioral or psychological problems in the light of difficulties in relationship with family members, peers, school and relevant social systems, to see if relief in any of these areas might reduce the need to "act out"; and also to see if some reconstitution of social experiences through new learning, new relationships and competencies and developmental activities could become the substance of "rehabilitative" or "corrective" work closer to the community than most institutions are. However, youngsters whose behavior and/or psychological disturbances would indicate they could endanger themselves or others may need institutional care for some time, with ongoing review of this need. The service plan for each child must also ensure services to the family so that intrafamilial and environmental interventions, as needed, will be adequate and relevant.

The advantages of institutional care consist in the capacity to garner multiple services and to integrate them to respond to the physical, emotional, educational, social, vocational and spiritual needs of youngsters who lack sufficient volitional control needed to live in a family type or non-restrictive group setting; they may often lack the control, also, to attend and use a community school. Youngsters who have such severe behavioral and/or psychological handicaps may need to have services brought into a therapeuticaly planned milieu and a contained environment, though not necessarily in a locked or physically secure facility. The use of the latter would be justified only on behalf of a youngster who by reason of psychosis is incapable of self-protection, or because of serious criminality.

Placement in an institution for the advantages of more comprehensive or controlled programming, on-site therapy, on-site schooling and training, etc., would be very inappropriate if children could attain these kinds of services in the community. Youngsters who are able to obtain acceptance in a community school (with the "given" of the mandate of the public school system to provide an appropriate educational program) should not be educated in an on-grounds school of an institution; and, in fact, it would usually be inappropriate for such a child to be in an institution rather than a group home or group residence.

In some *general institutions*, particularly where they are located in rural or suburban areas, there may be a tendency to bring *in* a larger range of services than is required by the child population, as an alternative to their going out to school, social activities, etc. The grounds may include not only a school but also

a medical clinic, a chapel and a gym, for example. As a result the children live in an environment segregated from the community.

As mentioned above, there are children so seriously emotionally or behaviorally disturbed that the consistency, predictability and structure which come in drawing services together become helpful. However, general institutional care, as contrasted with residential treatment centers which add to the above structure a high level of individualization and specialized services, will usually be inadequate and in that sense inappropriate. When the very intrusive and restrictive option of institutionalization is called for, there should be an assumption of need for a planned, specially staffed therapeutic program consisting of services which are selected and integrated by an inter-disciplinary team. Favorable ratios of staff to children to assure individualization, the selection of focused tasks which have direct relevance to the developmental and rehabilitative needs identified, service plans which are constituted by the team with child and parent(s) and monitored in regular progress reviews – all of these being conditions of a residential treatment program – will still allow a certain diversity of program models and specialization among centers.

To illustrate some of the possibilities for residential treatment programs, based on a broad sketch of population needs, three examples are given below:

Type A. Centers which are appropriate for and serve children whose disturbance is manifested by deviant behavior, impaired socialization or lack of impulse control, and who require not only individualized treatment but strong patterning of behavior through new relationships as well as very well organized activity programs, special education and skill building. Some centers may be further designed around a particular specialization for youngsters who are particularly susceptible to drug or alcohol abuse, for example. Others may be particularly designed to serve autistic children who have complex developmental, learning and behavioral problems and who need a strong psycho-educational program with one-to-one staff support and emphasis on skill and competency training, communication, attention building, etc.

Type B. Centers which provide for children who are emotionally conflicted or disturbed as shown in failed placements in other types of care, or in destructiveness to themselves or others or to property, or so lacking in reality orientation for their safety that 24-hour supervision would be called for. The setting would need to have capacity for strong psychiatric consultation to manage children with suicidal orientation, those with serious thought or affect disorders, or very rageful behavior. Although the symptomatic behaviors of some children may appear to reflect unusual pathology, e.g., self-mutilation, deviant sexual behavior, fire-setting, anorexia, severe accident proneness, continual disruptive confrontations, etc. there is great need to "treat" such children on the basis of a careful understanding of rejections, deprivations or provocations which may have fed into a "vicious cycle" of acting out, so that prolonged institutionalization does not come to reinforce the rage of abandonment and self-definition of being bad, evil, etc.

Type C. Centers which serve multiply handicapped children where there may be medical dimensions to their needs, such as neuromuscular, orthopedic or other organically related handicaps, or children with severe developmental lags which require highly specialized programming in order to prepare them for progressive movement to less restrictive, more normalized community living options. Such centers may also serve, for a time limited period, severely retarded children where such youngsters' handicaps are either secondary to another disability (medical or psychological), or associated with unusual neglect or abuse, etc., so that with intensive services the child may be prepared for a suitable plan of permanency.

Summarizing some major points to be observed in the use of institutional care:

1. This represents an option at the most restrictive end of the continuum of residential services; therefore, use must be justified by the severity of the need as well as the particular specializations and resources offered by the institution.

   Since general institutions cannot respond to those children with these severe needs, nor provide the specializations, they are never appropriate. They should not be used to accommodate neglected or dependent children who could be served in other forms of group care or family type boarding homes with special supports and services obtainable in the community or supplied by a sponsoring agency.

2. Although it is the child's special needs that lay the base for the selection of a residential treatment program, the services provided must always have in view a plan of permanency and the provisions of those helps to the family to enable them to supply a sustaining environment for the child or to relieve any factors contributing to the child's disabilities, and /or to participate in progressive planning on behalf of the youngsters.

3. Residential treatment centers may vary in program design, activities, and specializations, based on the best defined professional knowledge (to which licensing and accreditation organizations can contribute) about how remediation and developmental gains are enhanced. Program design should include commitments to utilize community resources and linkages, generic social supports, and/or graduated reduction of physical controls, as appropriate, so that institutional care is regarded as a strictly time-limited service leading to a clearly designated less restrictive form of care.

Other Variables Affecting Choice of Residential Care.

The developmental criteria of appropriateness for the differential use of the various forms of foster care have sometimes needed to deal with such factors as:

1. *Sibling group integration.* Exceptions to criteria of appropriateness for a given child may be claimed in order to avoid separation of a sibling group. For example, it has sometimes been held that a child of pre-school age who would nor-

WHEN PARENTS ARE NOT IN THE BEST INTERESTS OF THE CHILD

by
MARY-LOU
WEISMAN

ORPHANAGES are not what they used to be. They aren't even called orphanages anymore. The residents no longer sleep in metal beds, twenty to a dormitory room. At the Boys Town campus, just outside Omaha, Nebraska, children live eight to a suburban-style home, two to a bedroom. Bureaus have replaced lockers. Uniforms and standardized haircuts are gone. So are the long wooden tables where, in the orphanages of legend, children sat awaiting their portions of cornmeal mush for breakfast, or bread and gravy for dinner. For instance, at the former St. James Orphanage, in Duluth, Minnesota, known since 1971 as Woodland Hills, young people wearing clothes from places like The Gap and Kmart push plastic trays through a cafeteria line, choosing baked chicken or shrimp and rice. The weight-conscious detour to the salad bar.

In 1910 some 110,000 orphans lived in 1,200 orphan asylums throughout the United States. At the end of 1990, according to data from the American Public Welfare Association, there were approximately 406,000 children in out-of-home placements. About three quarters of these children were in adoptive and foster homes. About 16 percent, or 65,000, were emotionally disturbed children in need of therapy, most of whom lived in the group homes and residential treatment centers that are the institutional descendants of the orphanage. (The remainder, less than 10 percent, were cared for by a variety of temporary and emergency services.) What little research is available indicates that most of this smaller subset of "homeless" children have been physically or sexually abused, often by the adults charged with their care. At Boys Town, now a residential treatment center—and no longer just for boys—virtually all the girls and nearly half the boys have been sexually abused. The director, Father Val J. Peter, tells of a teenager who asked him on the day she arrived, "Who do I have to sleep with to get along here?"

Are some troubled children better suited to institutional care than to conventional family settings? If the answer is yes, as many child-care experts believe, then the fate of those children may rest on the outcome of a struggle now occurring between family advocates and advocates of treatment facilities, which rely heavily on public support

Child-care workers agree that children in residential treatment today are likely to be far more disturbed than the children who were in need of protective services twenty years ago and who, in turn,

Illustrations by Steven Guarnaccia

NICOLE BENGIVENO

The Children's Village, in New York: children there are never left unattended, not even when they sleep

were probably more disturbed than the good-hearted orphans with chips on their shoulders who preceded them. These kids have had it with parents—biological, adoptive, or foster—and the feeling is usually mutual. These kids do not trust adults, especially parents. They cannot tolerate the intensity of family life, nor do they behave well enough to attend public school. During a first screening at a residential treatment center a psychiatrist often asks a child, "If you had three wishes, what would they be?" Twenty years ago a typical answer was "I want a basketball," or "I wish my father didn't drink." Today, according to Nan Dale, the executive director of The Children's Village, a residential treatment center for boys in Dobbs Ferry, New York, one is likely to hear "I wish I had a gun so I could blow my father's head off." Child-care professionals call these young people "children of rage." Some of them take antidepressants and drugs to control hyperactivity. In addition to the behavior and attachment disorders common to children who have been abused and moved around a lot, some suffer from having been exposed *in utero* to crack and some from other neurological problems.

Most of the children who live in institutions are between the ages of five and eighteen. According to a 1988 study 64 percent of children in residential treatment centers were adolescents thirteen to seventeen years old. Approximately 31 percent were younger than thirteen, a percentage that has been increasing. According to the same study, the majority, about 70 percent, were male, a factor attributed to the more aggressive nature of the sex. Approximately 25 percent of the children were black, and eight percent were Hispanic.

A group home may house as few as four children, whereas a residential treatment center may be home to a hundred or more, although in either facility usually no more than eight to twelve are housed together, supervised by house parents or by child-care personnel working eight-hour shifts. At Woodland Hills an old three-story red-brick orphanage building has been renovated so that the first floor can be used for administration, classrooms, and the cafeteria. The second- and third-floor dormitory rooms have been divided into meeting rooms, staff offices, and apartments with bedrooms that sleep two.

Unlike the orphanages from which they are descended, most group homes and residential treatment centers are not meant to be long-term abodes. A typical stay at such a center lasts from several months to two years, after which most children return to their birth, foster, or adoptive families. A significant minority, those who either have no homes to return to or do not wish to go home, move on to less restrictive group homes or to independent living arrangements, also under the aegis of the child-welfare system.

HISTORY

THE first orphan asylum in the United States was established in 1729 by Ursuline nuns, to care for children orphaned by an Indian massacre at Natchez, Mississippi. Thereafter the number of orphanages increased in response to wars, especially the Civil War, and to epidemics of tuberculosis, cholera, yellow fever, and influenza. (Contemporary epidemics such as AIDS, the resurgence of tuberculosis, and the rampant use of crack cocaine have the potential to create another orphan crisis in the twenty-first century. By the year 2000, it is estimated, 100,000 children, most of them from female-headed households, will lose their mother to AIDS. Senator Daniel Patrick Moynihan, among others, foresees the return of the orphanage as inevitable.)

In spite of the Dickensian reputation that outlives them, orphanages, which began to proliferate in this country in the mid-1800s, represented a significant social reform for their time, just as the group homes and residential treatment centers that took their place are now seen as reforms. Before orphan asylums were common, orphaned, homeless, and neglected children, if they were not living, stealing, and begging on the streets, were housed, along with adults, primarily in almshouses, but also in workhouses and jails. The Victorian conviction that childhood was a time of innocence influenced attitudes toward destitute children. People came to believe that even street urchins could be rescued—removed to a better environment and turned into productive citizens.

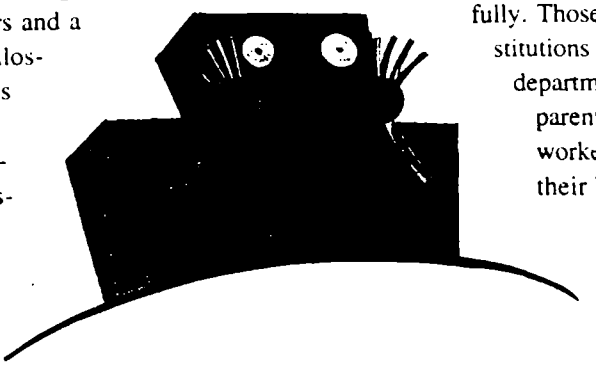
Most orphanages were private institutions, the result of the combined efforts of passionately committed "child savers," children's-aid societies, and a variety of mostly religious but also ethnic organizations that raised the money to build and maintain them. But even as the orphanage was becoming the nation's dominant mode of substitute child care,

an anti-institutional effort called "placing out" was under way, setting the stage for a debate that continues to this day. By the mid-1800s children were being transported on "orphan trains" from crowded eastern slums and institutions to the West, where they were adopted by farm families in need of extra hands. By the late nineteenth century, in a further move away from institutionalization, cottage-style "homes," which more closely mimicked family life and each of which housed about twenty-five children, began to take the place of large orphanages.

In the twentieth century, psychology—first psychoanalytic theories and then behaviorism—has dominated the field of child welfare. Unlike psychoanalytic theories, which focus on the child's inner personality, behaviorism emphasizes the way the child interacts with his world. In this view a child is not "bad"; his unacceptable behavior is. By changing the behavior, so the thinking goes, one changes the child. Behavioral theories replaced psychoanalytic theories, which were used only to limited effect by Bruno Bettelheim and others in the "homes" and "schools" for emotionally disturbed children which appeared mid-century. The therapeutic hour remains important, but what goes on in the child's life during the other twenty-three hours of the day is seen as potentially even more valuable. (A book by that name, *The Other 23 Hours*, by Albert E. Trieschman, James K. Whittaker, and Larry K. Brendtro, is the classic text of residential treatment.) The goal of residential treatment is to create a "therapeutic milieu," an environment in which everyday events are turned to therapeutic use. Any activity in a child's day—from refusing to get dressed in the morning to answering a question correctly at school to picking a fight—offers the child-care worker an opportunity to teach, change, or reinforce behavior through therapeutic intervention. Residential treatment aims to seize the moment while it is happening and the child's feelings are still fresh.

POLICY VERSUS REALITY

ORPHANAGES as such had virtually disappeared by the late 1970s as a result of a decrease in the number of orphans and a growing conviction that children belong in families. That every child needs parents and a home has become an article of faith and a guiding principle for social-policy makers and a matter of federal law as well. The philosophy of "permanency planning," as set forth in the Adoption Assistance and Child Welfare Act of 1980, considers the goal of the foster-care system to be keeping children in families. The law allows for but discourages "out-of-home placement"



—institutionalization in group homes or residential treatment centers—and calls for the return of the children to a family, biological or otherwise, whenever possible and as quickly as possible. But for many practitioners in residential treatment the law has become increasingly irrelevant.

Richard Small is the director of The Walker Home and School, in Needham, Massachusetts, a residential and day treatment center for severely disturbed pre-adolescent boys. Writing recently in a professional journal with Kevin Kennedy and Barbara Bender, Small expressed a concern shared by many of his colleagues.

> For at least the past decade, we in the field have been reporting, usually to each other, a worsening struggle to work with a much more damaged group of children and families, and a scramble to adjust our practice methods to meet both client needs and policy directives that may or may not have anything to do with client needs. . . . Those of us immersed in everyday residential treatment practice see these same guidelines as less and less applicable to the real children and families with whom we work. Many of our child clients and their families suffer from profound disruptions of development that we believe are likely to require long-term, multiple helping services, including (but not limited to) one or more time-limited stays in residential treatment. Despite a policy that seems to see clear boundaries between being "in care" (and therefore sick and vulnerable) and "reunified" (and therefore fixed and safe) our experience tells us that many of our clients are likely to live out their lives somewhere between these poles.

In keeping with the goal of permanency planning, institutions are supposed to maintain close communication with the parents of the children they treat. Many centers offer counseling for parents and for the entire family. The Children's Village runs evening and weekend programs especially for parents who have abused their children. At institutions that adhere most closely to the goal of reuniting parent and child, parents are encouraged to visit, and good behavior on the part of children is rewarded with weekend visits home. Green Chimneys, a residential treatment center that serves primarily inner-city kids, regularly transports parents and children in vans between New York City and its campus in Brewster, New York. Nationally, nobody really knows how many families are reunited, for how long or how successfully. Those who work with children in institutions complain that the pressure from departments of social service to reunite parent and child is so intense that the workers sometimes yield to it despite their better judgment.

The objective of residential care is to discharge healthier children into the care of healthier

parents—an outcome that authorities agree is desirable in theory but not always likely in fact. In their recent casebook for child-care workers, *When Home Is No Haven*, Albert J. [illegible]nit, Barbara Nordhaus, and Ruth Lord write that "one of the hardest tasks for a new worker is becoming reconciled to the inherent contradictions in the Protective Services worker's role. The worker is expected to aim for two goals, which in some instances may be mutually exclusive: reunification of the family, and protection of the child and the child's best interests."

THE VILLAGES

MODERN children who fall from the grace of their biological parents find themselves in what is known in welfare vernacular as the child-care continuum. Viewed simplistically, the continuum is a sequence of possible living situations, starting with the most homelike (adoptive and foster homes) and ending with the most institutional (residential treatment centers and psychiatric hospitals). Group homes, some for developmentally disabled children and others for dependent and neglected children, occupy the middle of the continuum. Generally speaking, children in group homes are less emotionally disturbed than those in residential treatment, but the continuum is far more complex and the boundaries between one option and another more porous than this description implies. For instance, children who are sufficiently emotionally disturbed to qualify for residential treatment are sometimes cared for in group homes.

In its desire to find a safe, loving, permanent home for every child, the system often becomes an unwitting abuser. The saga of Wendy, seventeen years old and living in The Villages in Topeka, Kansas, demonstrates the destructive potential inherent in the pursuit of permanence. Her experience at The Villages also illustrates a long-term institutional alternative for rearing some troubled children for whom parents may not be possible or desirable. (The names of children and some adults, along with a few insignificant details, have been changed, in order to protect the privacy of the children and their families.)

The Villages was founded by Karl Menninger in 1964, in response to homelessness, and now includes eleven group homes in Indiana along with the original eight in Kansas. (Menninger was one of the founders of the Menninger Clinic, which has no business relationship with The Villages.) The Villages is a nonprofit institution. Length of stay at The Villages is more open-ended than the two-year period prescribed at most residential treatment centers, as evidenced by the exceptional case of one young man who has been there since 1986. On the average, children spend about two and a half years at The Villages, although about 10 percent stay from three to five years.

The children in residential treatment today are far more disturbed than their counterparts twenty years ago.

Wendy was one of six children, no two fathered by the same man. "My mother," Wendy says, "was a slut." After their mother abandoned them, when Wendy was six years old, the state placed each of the children in a different foster home. Wendy was removed from her first foster home a year later, after being sexually abused by the older boys in the family. Because no new foster home was readily available, she was sent to a locked facility for juvenile delinquents, where the youngest inmate was fourteen years old. Two months later she was transferred to a foster home, where she lived for two months, until she returned from grade school one afternoon to find that her foster parents had moved, leaving no forwarding address. She moved in with one of her schoolteachers temporarily until another foster home could be found. This home, Wendy says, "was great," but the mother died and Wendy was transferred to yet another home. "It was pretty fun," Wendy says. "We lived on a farm."

At this juncture Wendy's mother turned up and asked to be reunited with her children, an experiment that was declared a failure within a year, whereupon Wendy was sent on to more foster homes and more sexual abuse. Wendy was placed at The Villages for the first time at the age of twelve. She remained there for three years, until an adoptive home was found. "The father tried to make it work, but the mother was never home," Wendy says. "She wanted me to clean. She wanted me to dress fancy. We had lots of verbal clashes."

A second attempt to find her an adoptive family failed when Wendy began surreptitiously to hit the couple's two-year-old baby. By that time Wendy was using knives and other sharp objects to make shallow cuts on the insides of her wrists—a behavior so common among abused children

Evening at The Villages in Kansas: "You should not feel as if you're in a treatment program"

DAVID WHITE

that those who engage in it have a name for themselves: "carvers." Wendy was sent to a psychiatric hospital for two months and then returned to the second adoptive home, where she again abused the baby. "I was afraid of getting too close," Wendy says. "I started trying to make things not work."

When Wendy was fourteen, child-welfare workers decided that she should spend some more time at The Villages before efforts were made to place her with another family. The day Wendy arrived, one of the house parents tempted the reluctant fourteen-year-old over the threshold with milk and cookies.

Once inside, Wendy set about reassuring herself about her most urgent concern: in this house of milk and cookies would she be safe from sexual abuse? "Is there a father in this house?" she asked one of the girls who'd been living there for several months. When she got yes for an answer, Wendy asked a second question: "Does the mother always believe him?"

Karl Menninger was convinced that a permanent home was the best therapy for troubled children. The job of house parent requires no training in advance, but by law house parents must attend at least thirty hours of professional workshops each year. The youngsters in The Villages seem to be kept on an even keel with such old-fashioned standards as church attendance, daily chores, clean rooms, neat dress, set bed times, and obedience to adults without fussing, plus, for some, the modest use of modern psychotropic medications and weekly visits to a therapist in the community. The Villages cares for many children who might otherwise be in residential treatment centers.

"The essence of therapy at The Villages is paradoxical: it's therapeutic, but you should not feel as if you're in a treatment program—the family *is* the treatment," says Don Harris, who until recently served as acting director of The Villages. "Some children are too problematic to fit into this setting. The Villages is not a place for violent children or those who have been so badly turned off parents that they don't want to connect." Weekly private visits between children and their social workers provide a check against abuse from house parents, in addition to another positive relationship with an adult.

Married couples preside over all but one of the homes. The exception, a household of adolescent girls, is headed by a single parent, a woman. Depending on the talents and interests of the house parents, each household encourages different kinds of family activities. Some households take their children to the symphony and stage family skits and musicals. Other households emphasize sports, or arts and crafts. The children attend public school in the community, although they tend to have more friends at home than among their schoolmates.

After two years Wendy's emotional health has improved dramatically. She has become very attached to the house mother and is a "big sister" to the other boys and girls in the household, who range in age from ten to seventeen. Wendy has done increasingly well in the public high school and plans to attend the University of Kansas. State child-welfare authorities, taking note of her progress, want to move her to an adoptive or foster home, but Wendy has her own ideas on the subject and doesn't want to go. "I was always told that when I got my act together, they'd leave me in one place," she says. "I finally did get it together, and now they turn around and say, 'Well, you're too good to stay here. We need to move you again.'" The State of Kansas spends about $19,000 a year to keep Wendy at The Villages. (The real cost is $26,000, but the difference is made up by private donations.) Family foster care in Kansas costs the state about $4,500 annually per child.

MONEY

Nan Dale, of The Children's Village, speaks for many others who believe that money, and not the needs of the children, drives the child-welfare system. "You've got to ask, after the second or third or fourth foster-care failure, when the child has set a fire, cut the cat's tail off, and attempted suicide, how come nobody has said, 'This kid needs treatment and not just another foster home'?" The fact that for the most part residential treatment receives its money from the same source as less expensive foster-home care does nothing to improve its image or encourage its use. In New York state, for example, where all forms of child care are especially costly, "regular" foster care costs about $39 a day per child. "Therapeutic" foster care, for which parents are trained and paid extra to deal with difficult children, costs $92. Stays in group homes cost $130 a day per child, residential treatment costs $135, and a day in a psychiatric hospital costs $800. Because psychiatric hospitals tend to keep children only long enough to diagnose and stabilize them—usually before sending them on to residential treatment centers, where they may stay up to two years—long-term residential treatment takes most of the fiscal heat. "No one sends a kid directly to an institution," says Sam B. Ross Jr., the founder and executive director of Green Chimneys. "You have to try everything else first. We don't do things by choice. We do ngs by finances. If you had funds, you would not let what ppens to these children happen to your child."

In addition to the administrative and maintenance costs associated with any institution, $135 a day reflects the costs of room, board, clothing, round-the-clock therapy, medical and dental care, and recreational and cultural programs. Children who enter residential treatment are typically up to three years below grade level. Many have severe learning problems as well as behavioral ones. At The Children's Village, for instance, a local school district operates a special-education program for kids with emotional, behavioral, and learning problems. The student-teacher ratio is six boys to one teacher and an aide. Even though food for the 315 boys at The Children's Village is bought at bulk rates, it costs about $5 a day for the younger children and $8 for adolescents. Annual clothing costs for the younger children are about $500, and for adolescents about $1,000, including an outfit for Sunday best.

Money flows into residential treatment from a variety of federal, state, local, and private sources, and the amount any agency gets depends on a number of factors, including how assiduously and creatively it works the system. At the federal level the Department of Health and Human Services and sometimes the Department of Justice appropriate money to the states. Licensing, required in order to qualify for federal unds, is up to the individual states. States match federal money using formulas that vary from state to state. The states then reappropriate the funds to the agencies that provide the care. The agencies are about evenly divided between public and private. Money at the local level most often comes from private sources such as churches and the United Way.

The children who enter the child-welfare system are almost always from the bottom of the socioeconomic ladder and therefore at the mercy of bureaucrats, policymakers, social workers, and judges. Where do people with money send their emotionally disturbed children when they can no longer tolerate them at home? If they don't ship them off to a tough uncle who owns a dude ranch in Colorado, or check them into a psychiatric hospital, chances are they enroll them in boarding schools described in their brochures as suitable "for the child who has special educational and emotional needs." The cost? About $36,000 a year, the price of many residential treatment centers and group homes, although private boarding schools do not pay for a student's clothing, medical and dental treatment, vocational training, or other extracurricular needs. Private boarding schools also carry no social stigma.

In the postscript to her memoir, *Orphans: Real and Imaginary*, Eileen Simpson writes about learning as an adult that the convent boarding school of her childhood, the Villa, was actually an orphanage. She was grateful for the deception, because the truth would have been "a heavy burden to me as a child," she says. "As an adult, it would have interfered with my view of myself as having been lucky. An orphan who goes to an orphanage is far more orphaned than one who goes to a convent boarding school."

"Institutionalism is in the eye of the beholder," Lois Forer, a former judge of the state Court of Common Pleas in Philadelphia, and the author of books and articles about children and the court system, said before her recent death. "Call residential treatment centers boarding schools." Forer observed that even the word "institution" can take on a very positive connotation when the right people are in residence. "The tubercular rich were sure having a high old time on the Magic Mountain," she said, "while the poor were in the slums coughing their lungs out."

INSTITUTIONAL FAMILY VALUES

In the paradoxical world of "child protective services," an institution may be the first home some children have ever known, providing their first chance to sit down to meals with other people at regular times, blow out birthday candles, and be taken care of by adults who do not hit or even yell. All but one of the staple ingredients of a happy home life are replicated in the best group homes and treatment centers. Intimacy is purposely missing. Love and family bonding may be what these children will need and be capable of having eventually, but for the moment the emotional thermostat must be set at neutral. These children are believed to be too disturbed to handle the intensity of real family life; that is precisely why they have been institutionalized.

Boys Town, in Nebraska: "We have a plan to change the way America takes care of her children"

The best institutions offer emotionally disturbed children a chance at a second childhood. They are given the opportunity to shed cynicism, develop self-esteem, and grow back into innocence and vulnerability. Candy will become a treat. This time they will be protected from harm. This time they will come to think of adults as kind and dependable. They will learn to play. They will learn to care about others.

Treatment communities teach Judeo-Christian values—the work ethic and the golden rule. Institutions offer vocational training and courses in computer literacy. At The Children's Village the best computer students teach their newfound skills to other children and adults in the surrounding communities, and The Children's Village has its own Boy Scout troop. The kids at Woodland Hills collect and pack supplies for national and international relief efforts. In addition, they split wood and deliver logs to the elderly in the Duluth community. Boys Town children host Special Olympics games.

A highly controlled environment is required to create a second childhood for severely disturbed children. Safety is the key issue. Keeping these children from harm involves more than keeping them safe from sexual abuse, physical abuse, drugs, and crossfire; they must be kept safe from themselves and their peers. Newly institutionalized children often try to run away. When a young person at Woodland Hills forgets to bring the appropriate book to class, two peers accompany the student back to the dormitory to retrieve it, thereby minimizing the possibility of an escape attempt. At The Children's Village burly guards equipped with walkie-talkies and trained in firm but gentle techniques of physical restraint stand ready to intervene should fights or tantrums develop beyond the regular staff's ability to control them. Children are never left unattended, not even when they sleep. In every one of the twenty-one cottages at The Children's Village one staff member remains awake throughout the night. The children in these cottages are sometimes suicidal. The bedroom doors in all the cottages open into the corridor, so that youngsters cannot barricade themselves in their rooms. Sexually abused children sometimes become sexual predators. At The Villages in Kansas some young girls will not allow anyone to comb their hair; for girls who have been sexually abused, even grooming can be too threatening.

This antidotal second childhood must be highly structured and predictable as well as safe. Treatment communities impose rules, chores, and schedules, and emphasize neatness, cleanliness, and order. "Everybody wakes up at 7:30 in the morning," writes eleven-year-old Robert, describing his day at The Children's Village, where hairbrushes, combs, toothbrushes, and toothpaste tubes are lined up with military precision on bureau tops. "The first thing we do is make our bed, wash our face, brush our teeth, last but not least put on some clothes. We eat our breakfast by 8:15 and do our chores. At 8:45 we go to school. In school the first thing we do is math, then reading and spelling. We go to lunch at 12:00 noon. . . ." Homer, the orphan hero of John Irving's *The Cider House Rules*, thrives on the routine of orphanage life. He enjoys "the *tramp, tramp* of it, the utter predictability of it." "An orphan," Irving writes, "is simply more of a child than other children in that essential appreciation of the things that happen daily, on schedule." A well-structured day serves the child as a kind of armature within which to build a new, less chaotic, inner self. "How to succeed and how to fail is very clear here," says

PHOTOGRAPHS COURTESY OF BOYS TOWN

Daniel Daly, the director of research at Boys Town. "These children are looking for consistency and for an environment they can understand."

Often institutions for children, like religions, have their own belief systems. What the faith is may not matter as much as its function as an organizing principle for its adherents. At The Villages the organizing principle is a belief in the therapeutic value inherent in family life. Woodland Hills is committed to a behavioral model called "positive peer culture." Any surrogate who remotely resembles a parent, or any scenario that draws its inspiration from a Norman Rockwell dinner-table tableau, is presumed anathema to this population of disturbed teenagers. Instead the kids confront one another in group therapy, and the staff gambles on its ability to turn the potentially destructive power of the peer group into a positive force. The Walker School, which adheres to a "cognitive behavioral model," has as its article of faith the conviction that every child can learn. As a result Walker places an unusually strong emphasis on academics, although "learning" at Walker can mean anything from solving math problems to practicing sitting still to running in the right direction in baseball. Green Chimneys is well known for using animals to encourage children to love and trust. Through "farm therapy" children learn to be care-givers even if they have not been cared for themselves, thereby helping to interrupt the cycle of abuse.

When it was an orphanage, Father Flanagan's Boys Town put its faith in God and the work ethic. Now that it's a residential treatment center, it also believes devoutly in science and technology. Father Val says, "Boys Town has embarked upon a program of basic research in microbehavioral analysis," the goal of which is to develop practical, replicable techniques for changing the behavior of emotionally disturbed children. These techniques are explained in a 250-page manual that is used to train the "family teachers" who head up each Boys Town "family." So "micro" is the behavioral analysis that the manual breaks down what Boys Town calls a "teaching interaction" into nine component parts: initial praise, empathy, or affection; description of the inappropriate behavior; consequence; description of the appropriate behavior; rationale for (benefits of) appropriate behavior; request for acknowledgment; practice of new, appropriate behavior; feedback; praise throughout the interaction.

BOYS TOWN: THE TEACHING FAMILY

BOYS Town is the most complete and controversial realization of the prevailing belief that a residential treatment center should look as little like an institution and as much like a home as possible. Indeed, Boys Town is much more than a happy home; it's a happy village. In fact it is a number of happy villages. Boys Town has cloned itself; by next year as many as seventeen little Boys Towns will be in operation in several states.

"We have a plan to change the way America takes care of her children," Father Val says. By saying so he sticks his finger in the eye of the child-welfare establishment, which considers Boys Town a bit overzealous, too lax in its efforts at family reunion, too independent, and too rich.

With net assets of $514 million, Boys Town is the Abu Dhabi of residential treatment centers. The place has its own schools, churches, town hall, firehouse, ZIP code, and two Olympic-sized swimming pools. A neighborhood of seventy-five variously styled houses, any one of which would sell for more than $400,000 in Fairfield County, Connecticut, is tucked behind flower gardens on 400 acres of specimen trees and dense, cushy lawns. Another 900 acres is farmland under cultivation. A man-made lake is stocked with bass and bluegill. Whereas other residential-treatment-center campuses have the slightly scruffy appearance common to boarding schools with meager endowments, Boys Town has the finely calibrated utopian look of an architect's rendering. The brick houses, with their picture windows and slate roofs, are set well back on generous lots and are furnished with plush wall-to-wall carpeting, Tiffany-style chandeliers, TVs, and Monopoly games. Clusters of "family" photographs decorate the walls and are displayed on mantelpieces. Bikes are parked in back yards, near handsome sets of lawn furniture. For the 100,000 tourists who visit each year, never mind the 556 boys and girls who live there (girls were first admitted in 1979), Boys Town evokes nostalgia for a Cleaverish community and home they probably never knew. The effect is intentional, if a bit surreal. All that comfort, all that beauty, all those possessions, says Father Val, a great believer in first impressions, send the children a message they may never have heard before: "You are valuable."

During dinner at a "family" home in Boys Town butter is requested with a smile and a "please" and acknowledged with a "thank you," and the presiding "parents," Linda and Geoffrey (not their real names), lavishly pass out praise along with the chicken enchiladas, rice, and mixed fruit. "I like the way you made eye contact with Judy when you asked for the butter," Linda says.

Linda and Geoffrey sit at either end of an oval table. The eight girls seated between them, four on each side, are clearly not their natural children. They are too close in age—eleven to seventeen—and not all of the same race. What they do have in common, besides histories of sexual and physical

abuse, is a set of learned behaviors that they show off with obvious pleasure. These girls greet a stranger with a big smile and a firm handshake. They also accept nonstop instruction in how to acknowledge criticism and take no for an answer. A child who six months ago would have turned the table over rather than respond to a request to set it now complies promptly and cheerfully.

Tonight, while the girls are learning table manners good enough for dining with Rockefellers, they will also be practicing their problem-solving skills. Jasmine, the youngest member of the family, has requested and been granted the privilege of presenting the evening's problem. Jasmine is nervous. She takes a deep breath and states her case. Jasmine is unhappy because her night to help prepare the family dinner is always Thursday, which also happens to be leftovers night. This means she never really gets a chance to cook.

"That was good, Jasmine, very good," says Linda, maintaining eye contact with Jasmine. "You did a good job of stating the problem clearly."

Jasmine smiles and blushes with pleasure. (Because a stranger has joined them at the table, tonight's problem and the ensuing discussion are trivial and tame. Under normal conditions the problem posed could have been "My parents don't care what happens to me." Such a statement might have prompted Linda or Geoff to help the child to clarify her problem for herself and for the other children: "Did something happen on your visit home last weekend?")

"Can you think of a way to solve the problem?" Linda asks Jasmine.

"Well," Jasmine says, "we could make Wednesday leftovers night."

The Walker School, in Massachusetts: "These kids get placed in families repeatedly, and they repeatedly fail"

COURTESY OF THE WALKER SCHOOL

"Good for coming up with a suggestion, Jasmine," Linda says. "That's one option. I can see you're really trying to figure this out. Can anyone else think of another?"

Over chocolate pie and milk, after a few more options have been raised and praised, the group turns to an eager but orderly discussion of the disadvantages and advantages of each of the options offered. "Can you think of any problems if you do that?" Geoff asks. "Can you think of any benefits?"

This is not a Stepford family. Although one might be tempted to see them as genial robots, rehearsing therapeutic dialogues from the Boys Town manual, they are also having a good time. David Coughlin is the second-in-command and the youth-care director at Boys Town. He acknowledges that behavioral psychodrama can sometimes look pretty stilted and silly, but says that it does only until the children have mastered the behavior. In this, their second childhood, these kids have to practice being normal. They are conscious that their behavior is being manipulated. They choose to play the game. The doors are not locked.

After dinner the girls move to the den, where they record on index cards the points they've accumulated throughout the day. Every day is parent-teacher-conference and report-card day at Boys Town. Point cards from school are carried home and compared with home cards so that everyone who works with a child knows how that child is doing. (At The Walker School communication and coordination are facilitated by a computer network. Throughout the day child-care workers and teachers feed in and retrieve information about individual children.) The object of all this attention, the child—whom Boys Town calls "the consumer"—also has ready access to the files. Some institutionalized kids can tell you exactly how many points they have the way some grown-ups can tell you to the dollar how much money they've got in the bank. Jasmine may have been awarded 10,000 points for her dinner-table presentation, but she may also have been docked thousands of points in school that day for failing to finish her homework. "Behavioral points are a lot like Catholic indulgences," Coughlin says. "We've got little sins, big sins, confessions, and plenary indulgences."

Points, awarded as flamboyantly as praise, translate into privileges and purchasing power. Thirty thousand points entitles a child to listen to a story on a cassette tape; a comic book costs 50,000 points. Adding and subtracting high numbers adds drama to the game and hones mathematical skills.

THE PROBLEM WITH PARENTS

WHEN parents treat each other and their children with patience, love, and consistency, they are making a "happy home." When child-care workers do the same, they are modeling parental behavior and creating a "therapeutic milieu." When parents instinctively intervene

from dawn to dusk to impart information or to comment on or calm a child's behavior, that informal activity is called child rearing. When child-care workers do it on a twenty-four-hour basis, it's called therapy. The good child-care worker, like the good parent, sees every event and encounter in a child's life as an opportunity to discourage destructive attitudes and behavior and replace them with healthy alternatives. Whatever particular philosophical model an institution may follow, all institutions agree that the most significant influence for change in a troubled child's life is the institutional parent or child-care worker.

Children's institutions must handle the issue of noninstitutional parents with the utmost delicacy. To some extent a natural hostility exists between parent and institution. Mistreatment by parents is one of the reasons that many children end up institutionalized. Nevertheless, the institution depends on the cooperation and rehabilitation of the parent to effect the ultimately desired family reunion.

Children typically enter a period of mourning when they are placed in a treatment center. No one insists upon loyalty to parents more than the institutionalized children themselves. In the introduction to *Love Is Not Enough* (1950), a book about his experimental school at the University of Chicago, Bruno Bettelheim wrote about a child named Emily who learned to handle conflicting loyalties to her parents at home and her counselors at school. "Asked what love meant, Emily answered, 'Love means to hug me and kiss me and carry me and put me down.' After a pause she added, 'Parents do it. Counselors becare you.'"

At The Children's Village a list of house rules written by the boys is tacked to a dormitory wall, along with posters of Magic Johnson, Michael Jackson, and Malcolm X. "No talking about a peer's parents" is rule No. 1, followed by "No stealing," "No lying," "No cursing or fighting," and "No damaging property or playing with fire extinguisher."

The eight girls who live with Linda and Geoff at Boys Town do not call them Mom and Dad or refer to them as "parents." Most intentionally, Boys Town calls the married couples who head up their seventy-five households "family teachers," a less intimate and more apt description. Even at The Villages, where exposure to healthy family living is the primary therapy, ten-year-old Melissa calls her house parents by their first names. Melissa, who starved while her parents dined, still clings to a family snapshot years after the court severed parental rights. "My parents locked me up in a closet and forgot about me," she says. "I miss them."

The critical challenge at Boys Town, as at all institutions for emotionally disturbed children, is to provide the child with a remedial childhood and remedial parental role models, within a remedial community, without challenging the child's loyalty to his real home or parent.

At the swearing-in ceremonies that take place nearly every Friday at Boys Town, Father Val is careful to tell the new arrivals, "You don't lose your own family, but you gain another family, a bigger family. You become part of the Boys Town family." When students gather in the assembly hall at Boys Town's Wegner Middle School to recite the Lord's Prayer, salute the flag, and sing the national anthem to heavy-handed accompaniment on an upright piano, they stand beneath a large computer-generated banner that reads "WE WILL NOT GIVE UP ON YOU." Even the concept of unconditional love—once associated exclusively with parents—has been institutionalized.

Institutional parents are too good to be true. They teach but never lecture. They praise but never blame. A child who has just thrown a chair through the bay window, hurled curses at the family teacher, and then slumped down on the sofa will be docked 50,000 points for the chair and the bad language, and then given 10,000 points for regaining control. "Look! You've already earned back ten thousand points. You'll be out of the hole in no time." These parents are upbeat. They are rational. They never say "Because I said so." What makes the good ones effective is the very fact that they are not real. These kids have already had real parents.

WOODLAND HILLS: POSITIVE PEER CULTURE

A FEMALE black bear is pawing through the Dumpster behind the old orphanage building at Woodland Hills. Some of the staff and a few of the kids have come out on the driveway to watch. Sixteen-year-old Kate cowers with fear, although she is about 300 feet from the bear and just one foot away from the back door. Six months ago Kate was a tough gang member. She stole a car and drove it through a store window. It was not her first offense. The judge gave her a choice between jail and Woodland Hills.

If Boys Town's style is "please" and "thank you," Woodland Hills's is "in your face." This is no corporate headquarters for family values; it's boot camp for juvenile delinquents. Forty-eight boys and girls, aged thirteen to seventeen, pound up and down the three flights of stairs that form the crooked spine of the old St. James Orphanage, founded by Catholics in 1910. The large, stern, Federal-style building, remodeled within to create smaller spaces, functions as a school, dormitory, cafeteria, and administration building. No attempt has been made to make the place look like anyone's home, real or imagined.

"When I got here, my hair was spiked," Kate says. "I was wearing combat boots, and my makeup was nasty. I liked my reputation, because nobody messed with me." Today she's wearing jeans, a T-shirt, running shoes, and no makeup. She proudly points to the pile of wood she has split. Then she walks over to a rabbit hutch, unhooks the door, and scoops up a big gray rabbit. "There's no drugs here and nothing to sniff," she explains, while the rabbit nestles in her arms. (Most of the kids at Woodland Hills have been substance abusers.) "They don't let us have anything that has drugs in it,

like bleach or gas, nothing that we could sniff and get high. We got to get trusted even before we can use the lawn mower."

No child-care worker is likely to be able to sell Kate on charm-school manners or a point system. Parental role models are out of the question. So, one would think, is getting these kids to give up street gangs for membership in teams with nerdy names like The Pioneers and The Trailblazers. But it's not—not any more so than getting an alcoholic to stand up that first time and declare. The power of Alcoholics Anonymous is well known, and getting former gang members to help other gang members go straight is also possible.

Positive peer culture is based on two simple Judeo-Christian principles: anything that hurts any person is wrong, and we are our brothers' keepers. The essence of peer culture is helping others. "No matter how troubled a person is, it always helps to get him off his ass and go do something for someone else," says Richard Quigley, who heads up Woodland Hills. "There's plenty else you've got to do for a real troubled person, but caring for someone else is the therapeutic ingredient you can't do without." The trick is getting these supremely careless children to care, first about someone else and then about themselves.

A newcomer to Woodland Hills gets placed in one of several pre-existing groups, each having about ten members. Young people of the same age, size, sex, and degree of sophistication are put together, although passive or aggressive kids are not likely to be concentrated in any one group. Unlike the teaching parents at Boys Town, who intervene all day long, correcting and reinforcing the behavior of their charges, group leaders at Woodland Hills intervene as infrequently as possible in the peer-group process. It is the kids who continually engage one another in therapy. Newcomers, who are used to defending their behavior with fists and knives, freeze like deer in headlights when veteran peer-group members gently ask them, "What are you gaining? What are you losing? Whom are you hurting?" Often the delicate balance of a group is upset from within by the charismatic presence of a "negative indigenous leader," or NIL in psychologists' shorthand. Even then a good group leader will not intervene directly. Such recognition by and confrontation with an adult leader would only enhance the NIL's status. Instead the adult leader attempts to disturb the NIL's social equilibrium by pulling the NIL's victim aside and confiding, "Take a look at how that guy is trying to influence you; watch how he's trying to get you off track."

"Working with a group is like practicing jujitsu," says David Kern, Woodland Hills's program director. "What am I doing? I'm taking your weight and your energy and your force, and moving it in the direction that you need to go. I'm not in fear of you coming at me. As a matter of fact I look forward to it, so that I can direct you."

Practitioners of peer-group therapy speak jujitsu English, using the delinquents' own words for and against them. Caring behavior is referred to as "strong," "cool," "powerful," and "mature." Hurtful behavior is relabeled "cowardly," "weak," and "childish." First you "talk the talk," they say at Woodland Hills; then you "walk the walk." If a kid hears and sees nothing around him all day for months but male and female group leaders modeling both strength and caring, after a while the message begins to sink in: "You are valuable."

An institution provides some children with a first chance to be taken care of by adults who do not hit or even yell.

Unlike most residential treatment programs, in which a stay may last as long as two years, the peer-culture program takes just eight months to complete. Kate spent the first two weeks at Woodland Hills in a stubborn state of resistance known as "casing the joint"—the first of five designated states in the peer-group process. "Nobody was going to tell me what to do," she says.

The language at Woodland Hills tends to be rough and to the point. At Boys Town teaching parents precede each corrective "teaching interaction" with an expression of appreciation, praise, or empathy for the child. At Woodland Hills group leaders also praise before they correct, but they call the procedure "bump and burp."

After she calmed down, Kate was invited to participate in an initiatory rite, the recitation of her "life history" before the girls in her peer group. Like the rest of them, she had been sexually abused. Like many of them, she had received counseling in her community and had lived in two foster homes, a therapeutic foster home and a group home, before Woodland Hills. Like most of them, she had been cared for by a single parent, her mother. Her troubles had started when she was thirteen years old and escalated quickly from skipping school to fistfights to drugs to breaking and entering to car theft.

Her peers listened to her story and offered their diagnosis, chosen from a prepared list of possible "problem labels." "My problem labels are 'authority,' 'inconsiderate to self,' and 'easily angered,'" Kate volunteers, rattling them off like name, rank, and serial number. "Inconsiderate to self" is a label applied to anything one does that is damaging to the self, such as putting oneself down or resisting help from others. In Kate's case the damage is literal. Kate is a carver.

Kate spent the next few weeks in stage two, "testing the limits." She refused to get out of bed in the morning. She would not attend school. "All I wanted was to get out," she says. She ran away twice. Both times staff members went out in the middle of the night to look for her rather than call the cops. That display of unconditional institutional love impressed her. "I didn't know that people who didn't know you could care about you," she says.

Then Kate entered the third, honeymoon stage of peer culture, "conformity." She behaved, but only because behaving was the thing to do. "I kissed butt" is how she puts it. "She really looked good," David Kern says, "but she still wasn't buying into the reason for behaving; she still didn't believe that she, or anyone else, was worthwhile."

Now Kate is in stage four, "value conflict." It's the critical stage. She wants to try the new way—to move on to the final stage, "change"—but the old way comes so much more easily. "I've got a lot of anger built up," she says. "I'm like a volcano or a time bomb. When I get angry, my old values come back. I, like, turn over."

Kate turned over in a big way at a group meeting when she got the news that the staff had decided not to grant her request for a weekend pass to visit her mother. She had carved on herself just a week earlier. They didn't think she was ready for a home visit. When her two best friends in the group tried to comfort her, she turned her fury against them, zapping them with exquisitely customized racial and sexual insults, making crude references to Peg's preference for black men and calling the promiscuous Georgia a "whore."

Today, after bullying the group for a week with silence, Kate, in classic peer-culture tradition, has asked for and been awarded a meeting of which she will be the subject.

"You built up all that trust with Peg and Georgia," a girl named Jane tells her, "and then you destroyed it in five minutes. Was it worth it?"

"My brother used to call me a whore," Georgia says. "You knew that."

"You shouldn't tell me stuff, 'cause when I get pissed off, I'll use it," Kate says, pulling a tissue from the box on the floor at her feet and wiping her tears.

"What would have happened if you'd let Peg and Georgia in?" another girl, Theresa, asks.

"I've tried before, and I've gotten hurt," Kate says. She kicks the tissue box toward Georgia. Georgia yanks out a tissue and blows her nose.

"She's vulnerable," Peg says.

"So it's 'I'll get you before you get me,'" says Lucie, the group leader. "Who else does that?"

"I do it, big time," Peg says.

"What's it gonna take," Georgia says, "to get you to start doing something for yourself?"

Kate doesn't answer. She just looks at her shoes.

"Kate," Jane says, with some frustration, "we're trying to care about you."

The meeting goes on like this for an hour and a half, until Lucie brings it to an end by complimenting the quality of the help given to Kate by her peers. She also credits Kate for working hard.

The questions asked of Kate are more important than the answers she gives. "A lot of people miss the point," Kern says. "The most important thing that goes on in a meeting is not whatever changes may or may not take place in the person who's getting help; it's the changes in the self-concepts of the nine people who are giving it. They deal with their own problems as they see them more sympathetically projected onto the youth who is the subject of the meeting."

Even so, Kate seems to have benefited from the meeting. "This place is really caring," she says. "They were crying because they were feeling empathy for me. They stuck to me like glue."

ARE INSTITUTIONS SUCCESSFUL?

"IT doesn't matter that a kid behaves well in front of you in a residential treatment center," says Earl Stuck, the director of residential services for the Child Welfare League of America. "We've only begun to use the power of residential treatment when we use it to help kids apart from their families. The real power of the tool is in figuring out ways to create the same kinds of change in families." What counts is what happens to children like Kate after they leave the cocoon of the institution and try to get along in the real world. Kate hopes that if she makes it through all five stages of the peer-culture program, she can go on to a career in the Army. That would be a resounding success. (Military service is a frequently chosen career among institutionalized young people, who find the continuation of a

PHOTOGRAPHS BY BOB STEVENS

highly structured life appealing. Twenty years ago a career in the armed services was a more realistic goal. Today, because many of these young people are more disturbed, the military is out of reach for a lot of "graduates.")

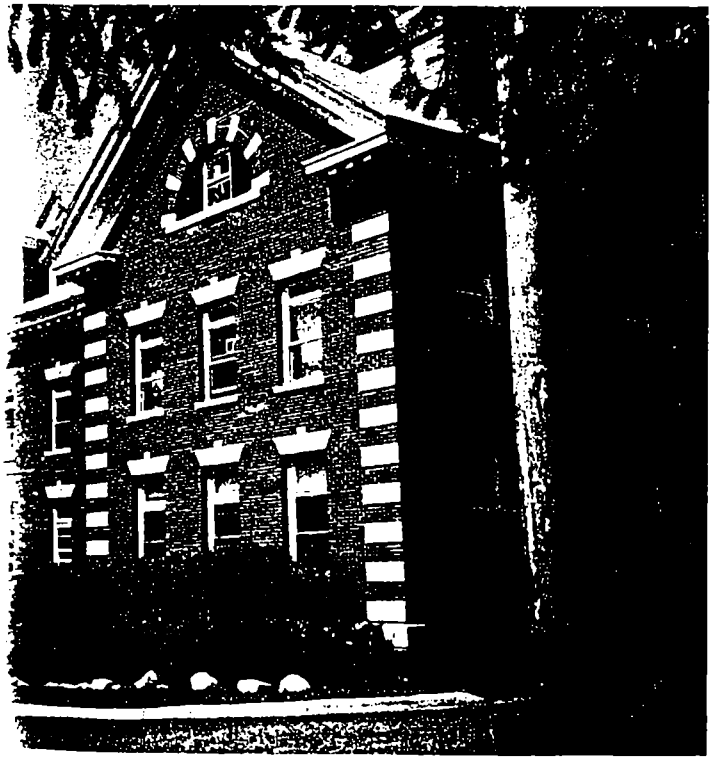
Very little solid research is available on the subject of whether or not institutionalizing children does them any lasting good. Researchers and child-care experts say that this lack of public accountability is due to a shortage of funds for research, which existed especially during the Reagan and Bush years. Indeed, experts disagree widely about what the criteria of success might be, let alone to what extent success may be achieved. Nevertheless, Stuck estimates that most residential programs do a good job. But Ira M. Schwartz, the dean of the University of Pennsylvania School of Social Work, discounts all claims of institutional success. Any studies conducted without a control group he calls "unsound." Even those few studies that have used control groups, he insists, are suspect and inconclusive: "No credible evidence shows that institutions are more effective than other, less expensive options."

Since 1964 American child-care institutions have been living uneasily with the good-news, bad-news results of a highly respected research project known as the Cleveland Bellefaire follow-up study. The bad news is that the benefits of residential treatment tend not to last once a child returns to society. Samuel Kelman, the present director of Bellefaire, which has a residential treatment center, doesn't think the bad news is altogether bad. "If a guy breaks his arm, and the doctor sets it, and the guy breaks his arm again, do you say the original intervention was not successful?" The good news, which attracted less attention at the time the results of the study were reported, is that institutions could improve success rates by working more closely with parents and with the community into which the child was being released.

Kelman takes the positive and negative findings of the Bellefaire study seriously. "We try to make the life experience of the kids while they are in our program conducive to learning what they are going to need to do when they leave the program. We teach them how to negotiate the system. We teach vocational skills, problem solving, and how to manage money. We do a lot of group work and give them a lot of feedback. Bellefaire is very aggressive about parent involvement. Our goal is to try to help them to increase their responsibility for rearing their own children. We plan home visits; we involve parents in decision-making while their kids are still in the program. But partly what we have is an attitude that we hope reflects respect for parents." A Bellefaire study completed in 1990 showed that 78 percent of children followed were still living at home three years after leaving treatment. Seventy-six percent were working or in school.

"Success" is defined modestly, even by those who run what are considered to be among the best residential programs in the country. Many, like Woodland Hills, gauge success in terms of recidivism. Eighty percent of the 160 young people who graduated from its peer program from 1989 to 1991 were not sent to other institutions during the year following their release. One year, David Kern says, is a reliable indicator of future success.

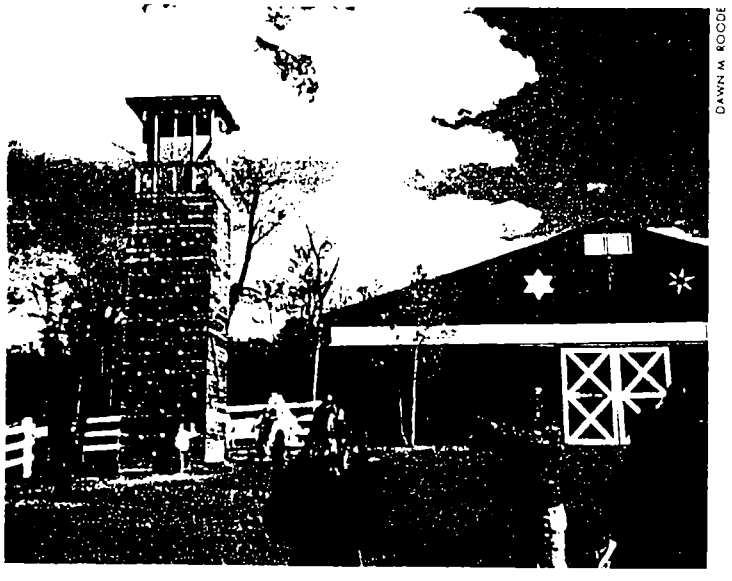
"When I was a kid," Sam Ross, the executive director of Green Chimneys, says, "my teachers used to say to me, 'If you don't pay attention, you're going to end up being a truck driver or a garbage collector.' Now I pray each night that my children will end up being truck drivers or garbage collec-



Woodland Hills, in Minnesota: "They don't let us have anything that has drugs in it, like bleach or gas, nothing that we could sniff and get high"

tors." Ross has no studies to prove that Green Chimneys's program is successful, but he has confidence in his own informal research techniques. He compares the numbers of grateful alumni who attend annual reunions with the number of requests for records he receives from community agencies, indicating that one of his graduates is in jail or other serious trouble, and he comes up with a positive assessment.

In 1984, with funding from an anonymous grant, The Children's Village initiated a pilot scholarship program called the W-A-Y (Work Appreciation for Youth). To qualify, boys had to have been at The Children's Village for at least six months and be able to read at a third-grade level. In the same year researchers established a comparison group composed of equally qualified students from The Children's Village who would not participate in the scholarship program but would



DAWN M. ROODE

Green Chimneys, in New York: every time a child is discharged, a bird is released in recognition

follow some less intensive course. To date 155 children have participated in the W-A-Y program. Participants must prove their mettle by performing nonsalaried chores and community service before moving on to salaried jobs on the campus, such as working on the gardening crew or at the Village Store. As the kids progress from chores to real jobs, they are taught to fill out job applications, negotiate salaries, conduct interviews, and accept criticism, and become subject to real-life consequences, such as being fired, for poor performance. In the final stages of the program, participants enter into a contract with The Children's Village—and with their parents, too, if they are available—in which the young person agrees to work part-time and save a percentage of earnings for a college education or job training. Savings are matched by private donors. Evaluations of the W-A-Y program made in 1993 indicate success. Twice as many scholarship students as young people in the comparison group had either graduated from high school or earned their high school equivalency degree. The dropout rate among scholarship students was 13 percent as opposed to 33 percent in the other group. For purposes of comparison (if severely emotionally disturbed children *can* be compared with children in the general population), the New York City public high school dropout rate from 1988 to 1992 was 16.2 percent.

In 1990 Boys Town concluded a longitudinal study that had begun in 1981, comparing the attitudes toward education and the attainments of a group of residents with those of a sample group of young people who had applied to Boys Town but did not attend. Among other findings, which included that the Boys Town residents estimated more highly both the importance of going to college and their own potential to complete college, the study demonstrated that the Boys Town kids did better academically and were far more likely to graduate from high school than the sample group.

PARADIGMS AND POLITICS

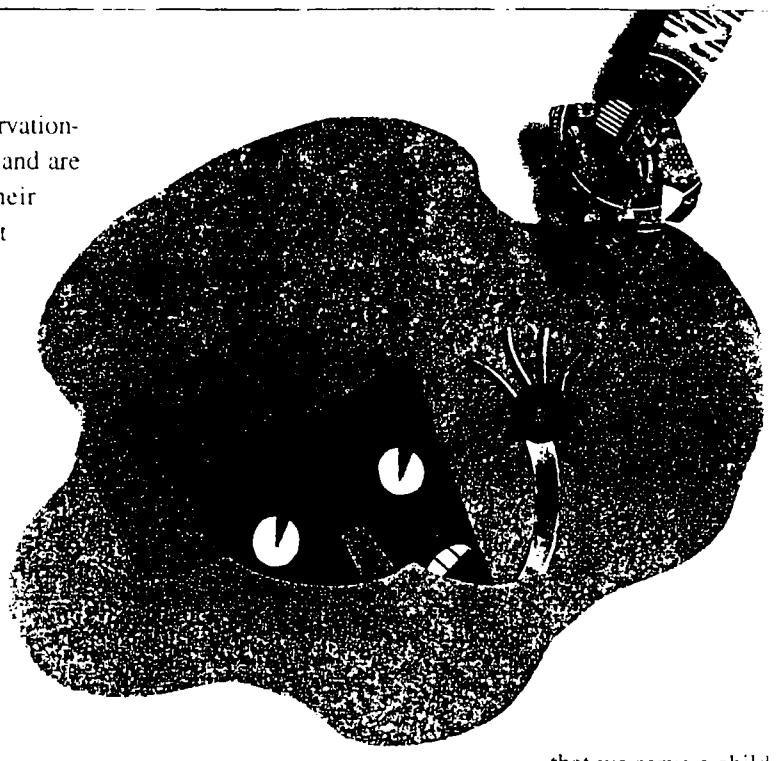
TWO years ago legislation called the Family Preservation Act was vetoed by President George Bush. The bill asked for about $2 billion to strengthen families. About half of that amount was earmarked for "family preservation"—programs to preserve troubled families *before* they broke up, so that fewer children would enter the foster-care system in the first place. Families in crisis would be assigned a licensed social worker, who would be available to them around the clock for a period of about three months, for help with problems ranging from substance abuse to landlord-tenant relations. Parents in imminent danger of abusing their children could find relief in a "respite program." Last year's budget legislation provided $1 billion for similar purposes, with a substantial portion also to be spent on family preservation. It had the backing of leading child-advocacy groups, including the Child Welfare League of America, the Children's Defense Fund, and The National Association of Homes and Services for Children. The Edna McConnell Clark Foundation has produced media kits claiming that family-preservation programs cost less per family ($3,000 for one family for a year) than family foster care, which it says costs $10,000 per *child*, or institutional care, which costs $40,000 per child.

Directors of some children's institutions are convinced that "family preservation" will take money directly out of institutional pockets. Sam Ross likes to point out that the family, theoretically the best way to rear children, also happens to be the least expensive. He calls this coincidence good news for advocates of family preservation, whom he calls "the liberal-conservative conspiracy." The way Ross sees it, liberal family preservationists believe that residential treatment centers are warehouses for children who could best be served in

homes in their own communities. Conservative preservationists are horrified by the cost of residential treatment and are looking for a cheaper alternative. "For once in their lives," Ross says, "they agree on something: let's get rid of residential treatment."

"It makes about as much sense as closing down emergency rooms and intensive-care units in order to lower hospital costs," says Brenda Nordlinger, the executive director of the National Association of Homes and Services for Children.

"Family preservation? Who can be opposed to that?" says David Coughlin, of Boys Town. "But," he warns, "some kids are going to be in trouble all their lives. These kids are always going to need help. You can't just blow across the top of a family for three months and expect their woes to go away."



Some directors of children's institutions worry that "family preservation" will take money out of their pockets.

As of this year The Villages in Kansas will be responding to pressure from the state, which provides 78 percent of its operating expenses, to institute a family-preservation program in addition to its group-foster-care program. One of the eight Kansas residences will be rededicated as a ninety-day "home away from home" for abused children. Meanwhile, therapists trained by The Villages will work with the abusing parents and the abused children in an effort to reunite the family. "We want to provide the services that the state wants to purchase. We'd be foolish not to," says Mark Brewer, who has been the executive director since last June.

Nan Dale, of The Children's Village, thinks that the fervor to reduce the numbers of children in residential treatment is reminiscent of what is now generally considered the disastrous policy of de-institutionalizing adult mental patients in the 1970s. Program directors are very skeptical about whether preventive-intervention programs are really as successful as their advocates claim. Those who believe that family preservation is being oversold see an ally in John Schuerman, a professor of social work at the University of Chicago. Schuerman has studied preventive-intervention programs and believes that many of the families that were treated and did not split up were not likely to split up in the first place.

Nan Dale is feeling the anti-institutional heat and resenting it. "We're as pro-family a place as you can find. The fact that we serve a child who has been removed from a family does not make us anti-family. We involve parents." Nevertheless, she says, "the lines have been drawn. When the words 'preventive service' got applied to everything up to the doorstep of residential care, some of us had apoplectic fits. We all would have told you that what we did here *was* preventive. We prevent lifetimes in mental hospitals, lifetimes in prisons. All of a sudden some bureaucrat in Washington defines preventive service as preventing placement outside the home, and we become the thing to be prevented." For the first time in anyone's memory The Children's Village, one of the largest and considered one of the best residential treatment centers in the country, has no waiting list. Dale says that children who might once have been sent there are being diverted to less restrictive, less expensive, and less appropriate options, such as foster-home care, on the presumption that a family setting is always better.

"What's in vogue right now is family preservation," says Father Val, of Boys Town. "Just follow the trend. Watch the little lemmings dashing toward the sea. They will tire of family preservation the way they tired of de-institutionalization. It's as if they just discovered that it's a good idea to try to keep kids in families. It's an exegesis of the obvious." Father Val thinks that the need to frame the debate as either anti-family or anti-institution is inevitable, given the longing that human beings feel for simple answers to complex questions. Certainly the people who make child-welfare policy, as well as those who carry it out, believe that the either-or approach is self-defeating. Nevertheless, it persists. Earl Stuck, who was one of the supporters of the Family Preservation Act, acknowledges the problem. "When you try to sell something politically, you have to oversell your case."

David Fanshel was until his recent retirement a professor at the Columbia University School of Social Work. A leader in the field of social work, and foster care in particular, Fan-

shel was the principal investigator in two major longitudinal studies on foster children in homes and institutions. At a time when many experts are questioning the value of residential treatment and promoting family preservation, Fanshel is going against the tide. He foresees a greater need for residential care in the near future. In fact, Fanshel, for decades one of the leading proponents of permanency planning, has modified his views. He now believes that permanent placement with a family is not an appropriate goal for about a quarter of the older, more seriously damaged and criminally inclined children in the system. He would like to see foster care reorganized into a two-tiered system in which permanent placement would remain the goal for the larger group, and the forestalling of criminal behavior through treatment would be the goal for the other group, which he calls "Subsystem B." He sees institutions playing a significant role in treating such dangerous children. The creation of two subsystems, Fanshel argues, "might help to avoid the inappropriate underfunding of Subsystem B now taking place in the interest of permanency planning."

The debate between family preservationists and those who advocate the wider use of institutions has been going on for decades. Until as late as the 1920s pro-family reformers used the "orphan trains" to place children with farm families. Today their anti-institutional counterparts, in their determination to provide a home for every child, sometimes resort to "adoption fairs," where difficult-to-adopt children are viewed by prospective parents. The social worker who organized one such event told a reporter from *Vogue* that although these fairs can result in the adoption of as many as half the children, "it felt like a slave auction."

Richard Small tells prospective adoptive parents, "If you're going to adopt a child from The Walker School, you're going out of your way to ask for trouble." Small is uncertain about whether it will be possible to find parents for six of the eight children at the school who were recently freed for adoption. One is a very disturbed twelve-year-old boy who has already suffered two failed adoptions. Small is faced with the opposite of King Solomon's conundrum: this time no mothers want the child. How hard should he try to find another adoptive family?

"Another adoption with this boy would be likely to fail," says Small, who also knows that another rejection might harm the boy more than a lifetime without parents. On the other hand, can he consign the child to such permanent and profound loneliness? "He has no one," Small says, "absolutely no one."

Small talked at length with the boy about the pros and cons of risking another adoption. Together, they had just about made up their minds in favor of life without parents when the boy wondered out loud, "Then who will take me for my driver's license?"

"I wish," Small says, "that there were a place, a group home, where kids could live at those times when they couldn't live at home. We've got a number of youngsters in this society—who knows how many?—who are capable of being connected to people, who wish to be connected, who should be connected, but who can't live full-time with the people they're connected to. When they do, terrible things happen to both sides, the kids and the caretakers. These kids get placed in families repeatedly and they repeatedly fail. What are we going to do with these children? Right now we either put them in an institution or we put them in a family."

GOING HOME

A GOOD children's institution is a hard place to leave. In the institutional world the child has the advantage; in the real world the child does not. The experts consult. Parents and children consult. Is the family ready? Is the child ready?

Twenty-five years ago 80 percent of the children who "graduated" from The Children's Village went home to some family member, most likely the mother. But starting about five years ago the percentage began to drop. Today only 55 percent go home to family. Nan Dale, citing her own subjective standard of measurement, the "GFF" (gut-feeling factor), estimates that half of that narrow majority are returning to a home situation that is fragile. At Woodland Hills, where most of the kids are released to the care of their families, David Kern says he feels uneasy about the prospects for success almost half the time. He calls sending vulnerable children home the worst part of the job. While he was at The Villages, Don Harris felt uneasy about returning kids to their parents about 80 percent of the time. "The reality is we can help these kids build some bridges to their families, but they probably will never be able to live with them."

Not sending vulnerable children home can also be the worst part of the job. People who work with institutionalized children continually face a quandary to which they have no satisfactory solution: What should they do when, in spite of everyone's best efforts, family seems not to be in the best interests of the child? What the system has to offer is life in a group home followed by independent apartment living, and then nothing.

Life without parents is a difficult sentence to pronounce upon a child, but it's happening more and more often. "Sometimes children have gone beyond the opportunity to go back and capture what needed to be done between the ages of three and eight," says Gene Baker, the chief psychologist at The Children's Village. "Sometimes the thrust of intimacy that comes with family living is more than they can handle. Sometimes the requirement of bonding is more than they have the emotional equipment to give. As long as we keep pushing them back into what is our idealized fantasy of family, they'll keep blowing it out of the water for us."

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CHILD WELFARE

CHILD WELFARE LEAGUE OF AMERICA • VOL. LXXIV • #1 • JANUARY/FEBRUARY 1995

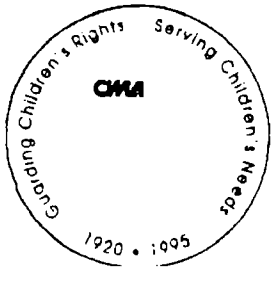
JOURNAL OF POLICY, PRACTICE, AND PROGRAM

SPECIAL ISSUE

Lessons from the Past: A History of Child Welfare

edited by

Eve P. Smith
and
Lisa Merkel-Holguin



CHILD WELFARE

JOURNAL OF THE CHILD WELFARE LEAGUE OF AMERICA, INC.

Volume LXXIV • # 1 • January/February 1995

DEPARTMENTS

BRING BACK THE ORPHANAGES? WHAT POLICYMAKERS OF TODAY CAN LEARN FROM THE PAST

Eve P. Smith

Contemporary proposals to revive the use of orphanages raise two questions: Is a return to orphanage care for children without special needs feasible? If so, would such institutions benefit children? Examination of the historical record of orphanages of the nineteenth and early decades of the twentieth century reveals characteristics that would make the creation of a new system of orphanages expensive and highly unfeasible. Proponents of new orphanages would also have the burden of disproving past criticism by professionals, based on the perceived harm done to children by institutional care.

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0009-4061/95/010115-28 $1.50

In many jurisdictions in the United States, proposals to "bring back the orphanages" are gathering momentum. Charles Murray of the American Enterprise Institute, a proponent of institutional care, espouses an end to AFDC payments to single mothers, with resultant savings to be spent on orphanages [1993]. Milwaukee Mayor John Norquist advocates the removal of children (and the termination of parental rights) of welfare recipients who refuse to accept jobs, and the placement of the children in institutions [Walsh 1994]. Both men have called for public action. Similar suggestions have also come from human service professionals who are looking for better ways to care for children of drug-addicted or HIV-positive parents. Joyce Ladner, a professor at Howard University, has concluded that finding families for "so-called high risk youngsters" is so difficult that "small-scale, caring institutions" should be created that can "offer children . . . a place they can count on to nurture them" [1989]. Even Sally Provence [1989], whose 1962 research documented the inferior development of institutionally reared infants, now suggests the use of institutions for some young children. The move toward the re-creation of orphanages for children without special needs has gone beyond mere discussion to serious consideration. The Illinois legislature, for example, has established a task force to study the need for a system of "child residential facilities" in Illinois.

What leads proponents to conclude that children's institutions are desirable or necessary? Some cite the growing rate of births to adolescent mothers, especially to teens 15 to 17 years old, and tell us that ending AFDC support to unwed mothers and placing the children in orphanages will reverse the current trend. Others believe that the current policy priority of maintenance of children in, or early return of children to, their own families or relatives is contrary to the children's best interests, and that they will be better off if they are reared in institutions. Still others point out that while the number of children living in out-of-home care is increasing (from 323,765 children in 1987 to 424,379, or

31.1% more in 1991), the number of licensed foster family homes has declined from approximately 147,000 in 1984 to 100,000 in 1990 [Merkel-Holguín 1993].

While the above issues deserve discussion, this article will focus solely on the efficacy of the solution. The policy changes now being discussed are antithetical to current child welfare policies and should be considered only after a careful review and analysis of all available data. Before making major changes, policymakers should be able to predict how long-term institutions for children might function in the current environment, and what children's experiences might be as residents of new orphanages.

This article reviews the historical picture, describing the orphanages of the past, their uses, population, funding, staffing, and contemporary views of the care they provided. Using this information, this article will attempt to answer two questions: Is a return to orphanage care feasible? If so, would the re-creation of orphanages benefit the children who would be placed in them?

The Emergence of Orphanages

The orphanage in North America appeared in the context of the development of specialized institutions for free persons who were perceived as needing special structure and training because they were dangerous to the welfare of society. Before 1850, outdoor relief was provided for destitute families in some localities, but other cities and towns built almshouses where paupers, including children with or without parents, could live and work.

Before 1800 there were only five orphanages in the United States, and by 1851, only 77 [Folks 1902]. The number quickly multiplied: Trotzkey [1930] noted that the 13 years from 1890 to 1903 saw an expansion of institutions, with 400 being established (see table 1). Consistent with a growth in the general population, the number of institutionalized children increased through the 1920s, though the growing use of free or boarding homes in the 1920s and 1930s resulted in a slight decrease by 1933.

TABLE 1
Growth in number of orphanages and children in orphanages in the United States, 1800–1933[1]

Year	*Number of Orphanages*	*Number of Children in Orphanages*
1800	5	—
1851	77	—
1880	613	50,579
1890	—	74,000
1900	—	85,000–90,000
1910	1,151	110,000[2]
1923	1,558[3]	142,971
1933	1,613	140,352

[1]Statistics taken from U.S. Bureau of the Census, (1910, 1927, 1935); Hart, H. (1892). The economic aspects of the child problem from *Proceedings of the National Conference of Charities and Correction* as quoted in Bremner, R. H., *Children and Youth in America, Vol 2*, p. 283 (Cambridge, MA: Harvard University Press).
[2]Includes a small number of children adjudicated delinquent.
[3]Includes 1,341 institutions for children only and 217 institutions accepting both children and dependent adults.

The number of residents per so-called *orphan asylum* varied. Although very large institutions existed, such as the New York Catholic Protectory, which in 1891 housed 2,000 children at one time, many institutions housed relatively few. In 1880, the median size institution held 42 children, and of the 960 agencies reporting to the U.S. Census Bureau in 1923, about one-fourth (27.5%) held fewer than 30 children. Almost two-thirds of the so-called *homes* (64.7%) housed fewer than 80. Despite the small number of large orphanages, however, many children lived in large institutions: in 1923 approximately 18% (25,350) of all orphan children lived in institutions holding from 250 to over 1,500 children [U.S. Bureau of the Census 1927].

Although there were a few state and county government institutions, particularly in the Midwest, the majority of North American orphanages were begun by religious groups, independent philanthropists, or "well-placed citizens with an eye to the

protection of society as well as the welfare of their inmates" [Sutherland 1976]. In New York, in reaction to Charles Loring Brace's program of sending children west to live and work with Protestant farm families, Jews started their own sectarian institutions, and Roman Catholics increased the number of theirs as well. In creating institutions, religious groups could ensure that children of their coreligionists would be brought up in their parents' tradition. In addition, Henry Dwight Chapin [1929] noted the popularity of the building and endowment of a great many institutions by some rich philanthropists to perpetuate their names. In addition to this measure of personal immortality, philanthropists could enjoy the visible evidence of their largess, which they could not do if children lived with their own or other families.

Life in the Orphanages

The institutions varied in number of residents, physical conditions, and atmosphere. It is generally agreed, however, that life in pre-1920 orphanages, and in many post-1920 orphanages, was likely to be regimented and sparse. Trotzkey, a proponent of what he termed "modern" institutional care, described conditions prevailing in most child-caring institutions until 1915 and continuing until the time he wrote in 1930. He used the term, "institutionalism," which meant "closed walls, children segregated from the community . . . commanded by the sound of the cowbell not by word of mouth, every minute of the day from rising to retiring regulated with mathematical precision, the child seldom seen apart from a line but moved in serried ranks, always marching." Corporal punishment was not uncommon, nor was "lack of understanding of the need of educational opportunities, lack of sympathy for the higher and finer interests of life . . . under which conditions alone is possible the relentless application of the iron heel and mailed fist which is all the more hideous when applied to defenseless childhood" [Trotzkey 1930: 64–65].

Statements and letters from former orphanage dwellers document the variety of institutional atmospheres: some depicted an environment that approximated Trotzkey's description; a few described a positive and loving atmosphere. Three examples illustrate the differences. First, the following statement, from a "national figure who wished to remain anonymous," described an impoverished environment:

> Life for a typical boy in an institution . . . meant essentially shelter, the actual necessities in the way of clothes, and food which primarily served the purpose of preventing starvation, rather than scientific or, may I say, common sense nourishment. The attitude of those responsible for the institution was that the boys and girls were unfortunate objects of charity. [Thurston 1930: 70–71]

Second, a statement by E. J. Henry, "an orphan asylum boy who became a superintendent," depicts not only impoverishment but also regimentation. Henry, whose widowed mother placed him in the orphanage and paid $1 per week for his care, described his experience. He noted that before he entered, he had had "the threat held over my head that if I were not a good boy, I would be put in an institution." He described the day room to which he was brought upon entrance:

> I found about twenty-five boys, averaging from six to fourteen years. . . . There were no furnishings in the room, except for a small table and chair, in which the governess, as we called her, sat. The floors were of rather rough boards, but very clean. It was the boys' job to do the scrubbing.
>
> When night came, we all had to be in our places in the playroom. We took off our shoes and stockings and placed them in front of the bench where we sat, before which we knelt for our devotional exercises. Then we

> formed in line and marched upstairs to the dormitories. There were ten iron beds . . . two boys slept in each bed . . . This dormitory was a very plain room—no pictures on the walls, and no furniture except the beds.
>
> In the morning when the rising bell rang, we all jumped up, dressed and marched downstairs where we washed and combed our hair. The dining room and kitchen were in the basement. We marched down single file, to long, roughly made tables . . . there was mush and milk for breakfast. At noon we would have soup and bread and water, or once in a while, chopped meat made into a gravy to put on our bread. At night we would have bread and milk—and only one helping. We growing boys were never satisfied when the bell tapped to get up from the table—there was no danger of stomach trouble from overeating. Very strict discipline was maintained . . . The girls' playroom was across the hall from the boys' and the playgrounds were separated by a high board fence. There would be weeks at a time when brothers and sisters in the same building would have no chance to talk with each other. [Thurston 1930: 77–79]

Third, the following letter from a former inmate of the Home for the Children of Seamen in New York implies a kinder, loving, and more benevolent atmosphere. In 1927, Mrs. McCabe of New York City wrote: "My name was Lizzie Walker brought up in that dear home for Seamen's children on Staten Island some 50 years ago. The only real home I have known and every one was so good and kind . . . That dear home is always in my memory."

By the 1920s, some institutions had modernized their programs. Uniform dress was discarded, food was improved, and children of many but not all homes were sent to public schools [Hacsi 1993]. Attempts were made to normalize the children's lives. Some philanthropists and wealthy institutions provided summer camp, books, magazine subscriptions, trips, and birth-

day presents. Now the best of homes were seen by some parents, professionals, and philanthropists as private schools for the poor, where children could receive more "advantages" than their parents could supply [Reeder 1929]. A number of model programs were developed during the second and third decades of the twentieth century. Institutions such as Edenwald, in Westchester County, New York, and Carson College for Orphan Girls at Flourtown, Pennsylvania, were lauded by professionals of the day and seen as serving specific populations well [Deardorff 1924].

Despite these improvements, some of the negative aspects of institutional life continued. Physical punishment, sometimes severe and abusive, was commonly used in institutions to control children's behavior, and extreme incidents were sometimes reported in the media. One late nineteenth century example described abuse that led to the death of an eight-year-old boy, Harry, who died following a severe beating by L.T. Prime, "caretaker of the boys' wing of the asylum." When the mother, a widow with nine children, five of them placed in the institution, visited the orphanage after being informed of her son's death, "some of his companions said that he had been taken from his bed and carried to the bathroom, where Mr. Prime had whipped him with a heavy cane . . . [Mr. Prime] admitted . . . that in severe cases he had stripped boys and beaten them in the bathroom . . . He has 140 children to look after." It is important to note, however, that the rules of the asylum forbade severe punishment [Affairs in Brooklyn. . . 1894].

Despite the asylum's policy, however, the use of corporal punishment was difficult to control and continued. The issue was frequently discussed in board meetings, and two staff members who used this method of discipline were dismissed in 1923 and 1924 [Smith 1993].

It is likely that sexual abuse was prevalent in group facilities, and was also difficult to control because so much of institutional life was hidden from the general public. Children may also have

been afraid of the consequences of reporting their powerful caregivers. Many occurrences, therefore, went unreported. A 1989 Royal Commission inquiry in Newfoundland, Canada, for example, documents widespread physical and sexual abuse involving pedophile Christian brothers in a Roman Catholic orphanage over a lengthy period of time. Although incidents of abuse had been reported to the police, over time, the abuse was glossed over and hidden from public knowledge by authorities who were unwilling to confront a powerful Roman Catholic hierarchy, and the perpetrators went unpunished for many years [Harris 1990]. Allegations and/or descriptions of sexual abuse may also be found in the literature and in case records. Bogen [1992], for example, noted the persistence of such activity through several generations of the Hebrew Orphan Asylum of New York. The case records of another institution reveal such statements as: "[Child] has told his mother of various sexual happenings at the Home . . . particularly about the relations of a man, the boys' caretaker, with one of the young girls" [Agency "Y" (Case Record D.M.) 1928].

The Orphanage Residents

Before the availability of AFDC or other financial support, residents of orphanages were likely to be children of the "worthy poor," young and generally well-behaved. Institutions could be selective about the children they accepted, generally preferring to serve those whose parents they considered "deserving"—that is, in need through no fault of their own. Institutions frequently discriminated against children whose parents were considered immoral. Children from "genteel" families, children born in wedlock rather than out of wedlock, and children whose poverty was a result of the death of one parent were preferred. Table 2 reveals the statistical disparity between all children in care and those placed in institutions. Of all the dependent children in out-of-home care in 1933, 57.8% were in institutions. Of all of the

TABLE 2

All Dependent Children and Dependent Children with One Viable Parent[1] In Out-of-Home Care, by Type of Care, 1933[2] (Percentages)

Type of Care	All Children	All Children with One Viable Parent	Children Born In Wedlock (Parent Not Viable)			Children Born Out of Wedlock (Parent Viable)
			Dead	In Inst.	Whereabouts Unknown	
	(N=242,929)	(N=115,476)	(N=63,517)	(N=11,760)	(N=23,204)	(N=16,995)
Institution	57.8	62.9	72.8[3]	58.9	62.9	29.0[4]
Boarding Home	27.3	26.1	19.2[4]	33.5	27.6	44.6[3]
Free Home	13.0	9.5	6.1[4]	6.3[4]	8.2	25.8[3]
Work Home	1.9	1.5	1.9	1.3	1.3	0.6
Total Percent	100.1	100.0	100.0	100.0	100.0	100.0

[1]For the purpose of this paper, *viable parent* is one who, given proper support, might be able to care for the child. Parents listed in the 1933 Census as being "at home" or "elsewhere" are counted as "viable"; parents "in institution," or "whereabouts unknown," are considered "not viable."

[2]Data taken from: U.S. Department of Commerce, Bureau of the Census. Table 24: "Children under each type of care, according to whereabouts of father and mother (39–40)." In *Children under institutional care and in foster homes, 1933.* (Washington, DC: U.S. Government Printing Office, 1935).

[3]Greater likelihood of receiving this type of care than all children, or children with one viable parent.

[4]Less likelihood of receiving this type of care than all children or all children with one viable parent.

children of widows or widowers, however, 72.8% were in institutions. Children born out of wedlock were more likely to be placed in boarding or free homes: only 29.0% were in institutions.

Agencies' own literature often described the type of child that would be admitted. The Leake and Watts institution, for example, stated that it accepted only "well-behaved . . . orphans of respectable parentage . . . physically and mentally sound. Disor-

derly and ungovernable children are not admitted" [U.S. Bureau of Education 1875: 118–120].

The term *orphanage* was a misnomer. A minority (approximately 10%) of all orphanage residents in 1933 were true orphans; the majority were children with one or two living parents. Even as early as the 1830s, available institutional beds were filled by children of single parents who had to work. The Orphan Asylum Society of the City of Brooklyn, for example, was founded in 1832 by a group of well-meaning citizens who mistakenly believed that a recent cholera epidemic would result in an abundance of friendless orphans. During the first year, however, only eight such orphans appeared. The remaining 18 children admitted were half-orphans, children of destitute widows, who [were] enabled by their daily labor, to pay the small sum of 50 cents a week for their support" [Orphan Asylum Society in the City of Brooklyn 1835: 4]. Most cholera epidemic orphans were taken in by relatives or friends, but many children were admitted who, by death, desertion, or institutionalization had lost only one parent, and whose remaining parent, while not able to perform the roles of breadwinner and homemaker at the same time, was able to work and pay a small sum for child care. Living in institutions also were children of two-parent families in which the caregiver was ill.

Other institutions followed similar patterns, some devoting themselves exclusively to the care of children with single parents. In 1875, for example, the Rev. Thomas W. Peters, D.D., a founder of the Sheltering Arms institution in New York, said his agency's services were needed because there were "many families abandoned by fathers . . . such mothers had little recourse but to "break up the household and go out herself to service" [U.S. Bureau of Education 1875: 271]. Similarly, many of the children of the Chicago Protestant Orphan Asylum in 1875 were described as having "one parent, who for various reasons cannot care for children in a home of their own, yet can contribute to their support in the asylum by paying a small amount for board" [U.S. Bureau of Education 1875: 60–61].

Statistics for 1933 demonstrate the continuation of these patterns into the first third of the twentieth century. More than half of all *dependent* children (51.8%) in institutions had one viable parent* [U.S. Bureau of the Census 1935].

That few teens were in institutions before the 1920s meant that the residents were relatively easy to control. Depending on the year and place, most impoverished children were employed by the time they were 12 or 14. Institutions followed the pattern of the larger society. By their teen years when they were likely to become troublesome, orphanage children were generally working—either indentured, placed in a *work home* (where work was to be exchanged for room and board), or returned to their own families and presumably contributing financially. When institutions began to keep children beyond the age of 12 or 14, they were faced with the problem of sometimes defiant, troublesome teenagers who were difficult to manage.

Children were expected to be compliant, respectful, and well-behaved, and were not to "talk back" to their adult caregivers. Although some disobedience was tolerated, for the most part, children whose behavior proved disruptive were either sent home or to other institutions. Letters to parents demanding that they "take your child home: we can't tolerate his behavior" were common. The widower father of one five-year-old boy, for example, was told to remove his child because Dr. LeGrand Kerr "made it very plain that it was impossible for [the institution] to keep him in a group with other children." The "home" was therefore leaving him with [the father] "as we know of no place to advise you to put him . . . . Hoping you will be able to find the right place for your little boy." This child was described as "abnormally troublesome at all times," hurting the smaller children, going into violent tempers, and kicking and biting anyone who tried to control him. He was "destructive, breaking his own and

*Parents are described as "viable" when whereabouts are described as either "at home" or "elsewhere" not "dead," "in penal institution", "in other institution," or "unknown."

other children's toys." He had "bad sexual habits," and needed constant watchfulness to keep him from teaching the other children "bad tricks." He was also "bright, a leader in kindergarten work, and loved music" [Orphan Asylum Society of Brooklyn (OAS) (Case Record 3370) 1927].

Another letter gave a mother one week's notice to remove her son, the superintendent noting that "I feel sure you will agree with me that he is a boy that needs individual attention which you as a mother will give him."[OAS (Case Record 3509) 1928]. In 1933, a child who could not be sent home was sent to another institution because he was considered "not suitable for the Seamen's Home." The board and staff were afraid that his behavior would "cause the Seamen's Home to get a bad name" [Society for the Children of Destitute Seamen (SCDS) 1933]. In 1939, a staff person, dissatisfied with the behavior of one teenager, reported to the Board of Managers of the Society for the Children of Destitute Seamen that this girl had been told that "the society was not going to continue to keep any older children who were not self-respecting and anxious to do for themselves; that we were not going to raise a generation of chiselers; and that unless her attitude was very different and unless she was willing to work and help herself we would have to transfer her to another Society" [SCDS (Case Record S.R.) 1935]. In May 1924, a letter was sent to the single-parent father of a 16-year-old girl described as a "troublemaker." It read, "The Committee feels that, as Gilda will be 17 this summer, she should leave the Home at the close of the school term. We will be glad to know what arrangements you make in reference to this matter"[OAS (Case Record 2870) 1924].

Although some children stayed for 10 years or more, others went home when widowed parents remarried, when deserting fathers returned, or when single parents could either take them or place them with extended family or friends. Other parents moved children from one institution to another, either because they were dissatisfied, or because financial arrangements were

more favorable at another home. Temporary placements were common: an analysis of the records of 109 children who were in the Orphan Asylum Society (OAS) during the 1920s revealed that 32% spent one year or less in the institution.* This is consistent with the 1933 national census statistics indicating that 36.8% of all institutionalized children had spent one year or less in the institution, and almost half (49.3%) two years or less [U.S. Bureau of the Census 1935]. Of all children released from OAS from 1913 to 1915, and 110 children released in the 1920s, 66% were returned to parents. When other relatives (such as grandparents, older siblings, aunts, or uncles) are added, 80% returned to families.** Returns were precipitated by parents who either took the children home or placed them with relatives, friends, or in another institution; or by the orphan homes, because the children or parents were not living up to institutional standards; or because the children had aged out.

Parental Involvement and Influence

The early assumption that virtually all dependent children were better off separated from their parents, and the widespread practice of discouraging parents from visiting with or having other involvement with their children, practically disappeared by the end of the nineteenth century. When parents were considered "worthy," when they were polite and respectable, and particularly when they paid for the care of their children, they were permitted to retain custody, to visit—at least monthly—and to send and receive letters. Most children not receiving public funding were supported at least in part by a parent. Parents who paid could apply to the institution of their choice and had the right to

*Fifteen percent of all residents of the Orphan Asylum Society of Brooklyn spent one year or less in the institution

**Fairly consistent with the 1913-1915 survey and the 1920s sample were the findings of a survey of all children released from the Orphan Asylum Society of Brooklyn from 1873 to 1875 and from 1883 to 1885. 62% of all children released during those years were returned to parents. An additional 13% were returned to relatives other than parents

maintain a relationship with their children and to visit, move, or remove them.

Institutional records contain notes and correspondence illustrating that parents were sometimes consulted and often maintained an active role in their children's lives. Many parents developed relationships with their children's caregivers and, when necessary, advocated for them. The records of the Orphan Asylum Society of the 1920s contain letters to and from parents that reveal a pattern of consultation and involvement. Parents were viewed as being ultimately responsible for their children and as having the power to make their children behave. A series of letters from the superintendent to the mother of a teenage girl, Phyllis, illustrates the expectation that parents could influence the behavior of their children. "The time has come when you and I will have to work together," stated the superintendent in her first letter. "There seems to have been quite a change in her . . . she has an indifferent air about almost everything and quite a 'high hat' attitude, which . . . must be curbed." The superintendent then described her unsuccessful efforts to make Phyllis behave: she had talked to her and had threatened to curtail her music lessons. She therefore asked the mother, whom she perceived to have greater power than she had over Phyllis' behavior, to "give Phyllis a real, motherly severe talking to; and, if necessary, do not take her out and give her as much as you have been doing." The superintendent's perception that she and parents shared responsibility is evident in a subsequent letter. She wrote: "Mrs. W., my responsibility is so great for your daughter and every woman's daughter and every boy in this place, that I do not feel that I want to carry it alone" [OAS (Case Record 3430) 1933].

One mother advocated for her son, explaining his behavior to institution personnel, and asking that he be treated with greater understanding. In a letter to the superintendent, she said that he "liked the institution but kept thinking of home and missed his freedom . . . He feels inferior to his school chums . . . due to the fact that he has to be in an Institution." She hoped that the

superintendent would "understand how he feels." She said that her son was "influenced by older boys in the home . . . he has promised me to try and do better." This mother moved her son to another institution several years later. In announcing the child's removal, she wrote that she felt "sorry for the boys and girls there who have no one to defend them" [OAS (Case Record 4000) 1930].

Staffing and Funding

Low personnel costs and minimal expenditures for food, housing, clothing, and recreation were common to most institutions. Institutionalization, therefore, was a fairly inexpensive way of caring for dependent children. In addition, congregate care was more likely to attract voluntary funds than boarding or placing-out. Parents' board payments also contributed to institutional budgets.

Personnel costs were minimized by the use of low-paid staff, members of religious orders, and volunteers. With the exception of a very few unusual homes operating after 1920, workers and teachers were selected in part for their willingness to accept low salaries or, in the case of the religious, maintenance only. Some institutions hired mothers of their own residents: in 1924, for example, Mooseheart in Illinois employed more than 80. Mature unmarried women who had few jobs open to them could also be hired for low wages and were therefore frequently employed in institutions [Deardorff 1924].

The best of these workers, dedicated individuals, contributed their all despite low recompense. The worst were exploiters of children, or at least, persons who were unable to obtain any other type of work. Some unmarried women dedicated themselves to the rearing of other people's children. One woman of this type was Miss Anna M. Drew, matron of the Home for the Children of Seamen, who died in 1906. Her obituary depicted a devoted woman whose charges, all under age 14, received more than

routine care. She was described as a "quiet, gentle but firm disciplinarian, with a loving motherly disposition, she won the friendship and respect of everybody near her . . . generations of boys and girls have grown up under her intelligent guidance." As a single parent, Miss Drew also adopted one of her charges [Miss Drew at Rest. . . 1906]. A description of another matron, however, as reproduced by Henry Thurston and told to him anonymously, reveals a very different attitude: "Well do I remember the . . . ridicule [matron] heaped upon me when I ventured to urge a plan of giving me an opportunity of entering high school. Her question as to "who had ever heard of an orphan boy having a high school education" reflected the attitude of the institution towards me . . . as well as the other boys" [Thurston 1930: 70–71].

By the 1920s and 1930s, the board and administration of the Child Welfare League of America (CWLA) were expressing concern regarding the qualifications of children's attendants, the difficulties of their jobs, and the low rates of pay. CWLA Board of Directors' minutes of 1926 described the conditions of work of some 5,000 cottage mothers:

> Most of them work for less than $50 per month with maintenance. Few of them get away from their strenuous duties for one full day each week . . . Often they have too little assistance . . . they find themselves loaded with responsibilities from 6:30 in the morning until 8 or 9 at night. Sometimes they must occupy living quarters which permit but little privacy. It is not strange, therefore, that women break down or are dissatisfied because of these burdens. [Special report . . . 1926]

In 1933, C.C. Carstens, the executive director of CWLA, discussed the seriousness of the situation. He pointed out that "[The cottage mothers] are usually untrained . . . and yet occupy the most important posts in the daily lives of the children." He also noted that the Great Depression "has led to serious reductions in

salaries that in the first place have never been adequate to ensure good service . . . A higher grade of cottage mother is needed in many institutions than is now generally found."

From the onset of the orphanage system and continuing into the 1920s and 1930s, board members and "lady manager" volunteers assumed many tasks currently assigned to professionals. Middle-class and upper-class women, with servants at home, assumed supervisory tasks as an extension into the community of normal tasks with their own families. Volunteer boards not only oversaw budget and made policy, but also made decisions regarding admissions and discharges and approval or disapproval of families to whom the children were to return or be placed out or adopted, and governed many other phases of the children's lives, deciding what they would eat, wear, and how much and how they would work and play. Board members and "lady managers" were regularly present at the institutions and oversaw their functioning [Letchworth 1886; Thurston 1930].

Few institutions were fully funded by government, and many received no public funds at all. Support came from memberships; small and large contributions; endowment; wise investments, including return from mortgages; membership dues; and direct board payments from parents. The 1933 U.S. Census report noted that a *minimum* of 76,252 (54.3%) of all institutionalized children and almost one-quarter (24.7%) of African American children received no public support at all [U.S. Bureau of the Census 1935].

Policy Changes and the Decline in the Use of Institutions

The decline in the use of institutions was preceded by at least 60 years of debate, and the conclusion, after the first 40, that family care was preferable to institutionalization. The debates began during the last third of the nineteenth century, and by 1886 were

well under way. While most opponents of orphanages accepted that short periods in receiving homes might be useful for some children, they were highly critical of long-term placement. Letchworth [1886] described the objections of these critics of institutions. They contended that: "the simple routine of the asylum does not give sufficient variety of mental or manual employment for proper development; and that the children thus become institutionalized, and graduate inefficient, lacking confidence in themselves to cope with the world in a struggle for a livelihood." Richardson argued that it is "hurtful, to retain in institution life, longer than . . . absolutely necessary as a preparation for outside life, those committed to it . . . it [is]not a natural condition" [Wolins & Piliavin 1964: 12, 22]. In 1896, Folks stated several reasons for preferring family homes over institutions: the institutions' "unbroken monotony. . . a measure of restraint and repression which tends to obliterate individual distinctions, to discourage originality and inquiry . . . practically no opportunity to learn the value of money," a lack of opportunity to develop "local relations and attachments which are a safeguard and an assistance in starting out in life," and little opportunity to develop continuing affections and relationship with adults. He asserted that children "need fathers and mothers" [Folks 1896].

The White House Conferences on the Care of Dependent Children in 1909 and 1919 were supposed to have settled the issue in favor of families, with preference given for helping children in their own homes through mother's aid. In 1909, Booker T. Washington, speaking out at the conference about "destitute colored children of the south," said that his "observation and experience" was that "in many cases the child would be better off if left to chance to get into some home than he is in the average orphan asylum." From his experience with former orphanage children who were enrolled at Tuskeegee, he had "become very suspicious of the average orphan asylum, organized and built up for the support of the members of my race" [Washington 1909: 114–117]. The 1919 conference emphatically endorsed the state-

ment, "The carefully selected foster home is for the normal child the best substitute for the natural home."

Articles by advocates for family care and against institutions for children began appearing in professional journals and the popular press during the second and third decades of the twentieth century. Henry Dwight Chapin, M.D., the founder of a family care agency, wrote in 1926 that the United States was an "institution ridden" country, and cited experts who substantiated his position that family care was superior. Professor Boas of the Jewish Bureau of Social Research found that "children in boarding homes showed a much better physical development than children in institutions." Prison warden Mott Osborne said that "an undue proportion of his prison wards had their early training in institutions" [Family vs. Institution 488]. The Literary Digest [1921] described a highly successful "experiment" by the board of trustees of Hancock County, Ohio, in which children were boarded out rather than placed in institutions. Sophie Irene Loeb, a reporter, not only produced many anti-institution articles but also organized the Child Welfare Committee of America, Inc., an organization of prominent Americans, and held two conferences (1925 and 1928) at which professionals and politicians voiced their opposition to institutions. Ethel Verry [1939] listed problems facing children who graduated to the community after long periods of institutional care, describing difficulties in economic adjustment (too little realism in use of money, too few opportunities for making choices), family adjustment (difficulty in accepting family and personal imperfections, setting schedules, meeting appointments), and personal adjustment (making adequate personal social lives, making adequate marriages and relationships with partners, making lasting, not superficial relationships).

During the 1940s and 1950s, institution personnel also spoke of the limitations of institutional care. At a meeting of the Association of Children's Institutions in Syracuse, New York, on April 16, 1948, Miss Lillian Johnson, Executive Director of the Ryther

Center in Seattle, Washington, said that the pretense that an institution is a home must be given up, that most children come to institutions because there is no other place for them and that they must be prepared for going elsewhere. She noted that an institution is not life and cannot be made to be. She compared the institutional plan to a life jacket that holds the child above water but without putting solid ground beneath the child's feet. At a 1952 institute for institutional personnel given at Case Western Reserve University, Morris Mayer, the executive director of Bellefaire, in Cleveland, an orphanage that became a treatment center, characterized the best-rated institutions as third choice, after the children's own homes and family foster homes. He believed that institutions should be used only for those children with personality difficulties who could not adjust to families [Thomas Orphan Asylum (Box 2 Folder 6)].

The impact of preference for family over institution, in conjunction with the development of the ADC program as part of the 1935 Social Security Act and the continuing development of foster boarding care, was felt over the years. While the number of children in out-of-home care increased from 1951 through the 1960s, the percentage of children in institutions dropped significantly, from approximately 43% in 1951 to 31% in 1962 [Wolins & Piliavin] and from 21.5% in 1982 to 17.1% in 1989 [Merkel-Holguín]. Most institutions either closed or were transformed into residential treatment centers for the emotionally disturbed.

Lessons for Today

Is it feasible to re-create the orphanages? The preceding pages describe the orphanages and the conditions that enabled them to develop and continue well into the twentieth century. In the last several decades, however many structural and demographic changes have taken place in society, and the re-creation of orphanages would therefore be extremely expensive and so difficult as to be virtually impossible. Three changes stand out.

First, the old orphanages depended on having a population that was generally well behaved and easy to control. Today's children differ in behavior. Before the 1920s, most children in institutions were young. Children generally graduated to the work world by the time they were 14, either sent home to their own families or placed out. When institutions began to keep children through the high school years, the population became more difficult to control. Today's children enter the adult world at about 18, so institutions would have to deal with adolescents.

In the past, children living in institutions were the most, not the least, desirable of all children cared for by child welfare agencies. The old institutions preferred to care for children whose families were respectable and worthy by the standards of the day. In addition to selective admissions, institutions could, and frequently did, get rid of troublesome children by sending them home or to another institution, or by placing or boarding them out. In this manner, they could maintain a population relatively free of children who were difficult to control or who would exert negative influence on others. Given the present preference for family care over institutional care, institutional residents are likely to be those with the most, rather than the least, behavior problems.

Second, unlike parents of the past who had some influence and power to determine the course of their children's lives, most of the parents of children currently being considered for institutional care will be unable to retain control and custody, advocate, and move their children if the children are subjected to poor conditions or to abuse. Because many parents in the past paid for their children's board, they could and often did move or remove them from the care of a particular institution, either taking them home, moving them to another institution, or placing them privately. They could oversee their children's care, explaining their behavior and acting as advocates with institutional personnel. Though some children lived in orphanages on a long-term basis, many children were only temporary boarders. Most children returned to parents or to other relatives.

Unlike the many children of the past, today's children will be more likely to spend most of their growing-up years in institutions. The proposed curtailment of welfare payments to unmarried mothers, and time limits on welfare benefits, will mean that, even if parents are employed at minimum wage jobs, few will have the resources that will enable them to assume the care of their own children. Given the lack of financial support for families and the increasing incidence of parents whose drug habits make them unsuitable custodians, it is likely that the length of time children spend in care will increase, and that children will be less likely to experience family life at any time during their childhood years.

Third, in comparison to the orphanages of the past, contemporary costs to the public for institutional care would be extremely high, and would be borne almost entirely by government. Not only did many parents make board payments, but the old institutions also attracted endowments and contributions from philanthropists, religious organizations, and well-meaning individuals. Philanthropy now follows different channels, and government has largely assumed the cost of contemporary child welfare. It is unlikely that private money can be diverted back to support orphanages. If it cannot, the public purse will have to bear the whole cost. This includes a large up-front expenditure for capital costs for renovations and/or new buildings.

In addition, it appears unlikely that orphanages can be reconstituted to operate at reasonable cost. In the past, expenditures were minimized by the utilization of low-paid, untrained personnel, members of religious orders, and middle-class and upper-class women who contributed time to overseeing the facilities and decision-making. Such low-cost personnel are no longer available, and health, safety and other regulations now mandate higher staffing ratios and consequently higher staff costs. With the current emphasis on social welfare retrenchment, adequate funding is unlikely.

In practical terms, the re-creation of orphanages without such adequate funding would be highly unrealizable. However, if, for discussion sake, it was assumed that the public would be willing to pay the bills, another question would remain: Would the re-creation of orphanages benefit the children who would be placed in them? Opinions and experiences of past professionals, quoted above, lead one to believe that the children would be harmed more than they would be helped. Advocates for modern-day orphanages might argue that they would not intend to re-create the harmful aspects of orphanage life, but would create new forms of institutionalization that would benefit the children. Based on the historical record, however, they face a very high burden of proof that this can be done. If history is any guide, the experiential evidence is to the contrary.

Aside from history, there is contemporary evidence that institutions can be harmful to children. For example, although abuse may also a be problem in children's own families and in some foster homes, it appears to be more prevalent in institutions.* The problems described by Folks and other family advocates, and the reasons they gave for preferring families, seem still valid.

Goldstein et al. [1973] have corroborated the experiences of earlier professionals and advocates, describing the reality that constant changes in caregivers and a lack of what they describe as "psychological parents" create children who tend to be behind other children in skills, achievement, and social adaptation. The consequences of this deprivation become even more apparent in adulthood, when the lack of self-love and self-regard leads to a diminished capacity to love and care for others, including the individual's own children. ♦

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*Current statistics imply a rate of founded or substantiated abuse or neglect in institutions to be more than twice that of abuse or neglect incidence in foster homes. According to Merkel-Holguin [1993], 13 states responsible for approximately 30% of all children in out-of-home care provide statistics for number of children in out-of-home care, and number of founded abuse and neglect cases for institutions and foster homes. Applying the latest estimate (1989) that 17.1% of all children in out-of-home care live in group homes, residential institutions, and emergency shelters, it appears that in those 13 states, approximately 5.1% of institutional children and approximately 2.2% of children living in foster homes are victims of reported and founded abuse and neglect. Based on the rationale stated in the text, even these figures are likely to be underestimated.

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Order Code IB95029

CRS Issue Brief

Child Welfare, Child Abuse, and Related Issues in the 104th Congress

Updated May 1, 1996

by
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Congressional Research Service • The Library of Congress

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Child Welfare, Child Abuse, and Related Issues in the 104th Congress

SUMMARY

President Clinton on January 9 vetoed the conference agreement on omnibus welfare reform legislation (H.R. 4, H.Rept. 104-430). Earlier, Congress had included a similar but not identical version of welfare reform legislation in the budget reconciliation package (H.R. 2491), which President Clinton also vetoed. The National Governors Association has since approved modifications to H.R. 4, in an effort to move toward compromise. Both the House Ways and Means Committee and the Senate Finance Committee held hearings on the Governors' proposal in February.

The conference agreement on welfare reform would allow foster care maintenance and adoption assistance payments to remain open-ended entitlement programs, as under current law. However, the following programs currently authorized under the Social Security Act would be eliminated and replaced with a Child Protection Block Grant to states: child welfare services, family preservation and family support, independent living services, and administrative and training costs related to foster care and adoption assistance.

The Child Protection Block Grant would begin in FY1997 and operate as a capped entitlement to states; i.e., states would be entitled to their share of a nationwide ceiling or "cap," starting at $2 billion in FY1997 and rising to $2.8 billion by FY2002. In addition, $325 million in discretionary funds would be authorized annually for the block grant. State allocations would be based on the share of funds received by states in previous years from programs replaced by the block grant.

H.R. 4 would create a second block grant to states, called the Child and Family Services Block Grant, that would replace the existing Child Abuse Prevention and Treatment Act (CAPTA) and several small related programs. This block grant would begin in FY1996, at an discretionary authorization level of $230 million in FY1996 and such sums as necessary thereafter. Of these funds, 12% would reserved for the Secretary of Health and Human Services to conduct research, demonstrations, training and technical assistance. An additional $16 million would be provided to the Secretary for a national random sample study of child welfare and other research, and funds would be provided for the Department of Health and Human Services (HHS) to continue an existing court improvement grant program.

The Governors' proposal would continue foster care and adoption assistance as open-ended entitlements but would allow states the option of receiving funds for these programs, plus the independent living program, in the form of a block grant. The governors would convert all remaining child welfare and child abuse programs into a capped entitlement block grant.

Meanwhile, on March 19, President Clinton submitted his FY1997 budget proposals to Congress. In FY1996, child welfare and other programs administered by HHS have been operating under continuing resolutions, in the absence of final action on the FY1996 appropriations bill, H.R. 2127. The current continuing resolution is in effect through April 24, although the child welfare services program under Title IV-B of the Social Security Act is funded through the end of the fiscal year.

MOST RECENT DEVELOPMENTS

The House Ways and Means Committee on May 1 ordered reported the Adoption Promotion and Stability Act, H.R. 3286, that is intended to remove barriers to interethnic adoption and to promote adoption through tax incentives. The bill is expected to reach the House floor during the week of May 6. The interethnic adoption provisions also were included in omnibus welfare reform legislation, H.R. 4, passed by Congress last December and vetoed by President Clinton on January 9, 1996. H.R. 4, as passed by Congress and vetoed by the President, would consolidate child welfare programs into block grants to states. Foster care maintenance and adoption assistance payments were excluded from the block grant, although administrative and training costs related to foster care and adoption would be consolidated into the block grant. Child welfare programs have been operating during most of FY1996 under temporary continuing resolutions. However, on April 26, a full-year appropriations bill was enacted (P.L. 104-134). Meanwhile, on March 19, President Clinton submitted his FY1997 budget request, including funding for child welfare and related programs.

BACKGROUND AND ANALYSIS

Introduction

President Clinton on January 9 vetoed the conference agreement on omnibus welfare reform legislation (H.R. 4, H.Rept. 104-430), that was passed by Congress in December. Earlier, Congress had included similar welfare reform provisions in budget reconciliation legislation (H.R. 2491), which was also vetoed by President Clinton. Most recently, the House Ways and Means Committee has reported legislation, H.R. 3286, that would prohibit discrimination in adoption and foster care placements and establish tax credits for adoption. Similar anti-discrimination provisions also had been in the vetoed welfare reform bill, and identical tax credit provisions were included in the vetoed reconciliation bill. This issue brief describes existing child welfare and child abuse programs and describes actions taken by the 104th Congress that would affect these programs.

Existing Federal Programs

Care and protection of abused, neglected or at-risk children is an area of domestic relations where state law is generally paramount. The federal government plays a significant role by making funds available to states through several programs targeted at child welfare activities, and by attaching requirements that states must meet to receive funds under these programs. The federal programs are varied in terms of their administration, allowable activities, and target populations. Nonetheless, the federal role is limited and most child welfare policy is established at the state level.

Child welfare services delivered at the state and local level include: investigation of reports of child abuse and neglect; preventive and supportive services to children and their families; financial support for children in foster care; services to reunite children with their natural families, if possible; and adoption assistance or other permanency planning services for children if family reunification is not feasible.

The programs below constitute the largest federal child welfare programs and those that would be affected by actions taken in the 104th Congress. They are administered by the Department of Health and Human Services (HHS), Administration on Children and Families. FY1996 appropriations (as provided in the full-year appropriations bill, P.L. 104-134, enacted April 26), and the FY1997 appropriations level requested by President Clinton are shown.

Social Security Act Programs

The largest federal child welfare programs are authorized under the Social Security Act, with most federal spending devoted to the maintenance and support of low-income children in foster care. These programs, which are under the jurisdiction of the House Ways and Means and Senate Finance Committees, are:

Child Welfare Services (Title IV-B, Subpart 1). Permanently authorizes grants to states for child welfare services. States have wide discretion in designing programs, but must provide certain protections for all foster children as a condition of funding. The federal matching rate is 75% and state allocations are based on per capita income and population age 21 and under. This program is not an entitlement, but is subject to the discretionary appropriations process. *FY1996 funding*: $277 million. *FY1997 Administration request*: $292 million.

Family Preservation and Family Support (Title IV-B, Subpart 2). Authorizes grants to states for family preservation and family support services through FY1998. The program is a capped entitlement to states, i.e., states are entitled to their share of funds according to a formula, subject to a nationwide ceiling. The ceiling began at $60 million in FY1994 and is scheduled to increase to $255 million in FY1998. (Beginning in FY1995, a certain portion of funds are reserved for grants to state courts to assess and improve their child welfare proceedings.) The federal matching rate is 75%, and state allocations are based on the number of children receiving food stamps. *FY1996 funding*: $225 million. *FY1997 Administration request*: $240 million.

Foster Care (Title IV-E). Federal matching funds are permanently authorized and provided to states on an open-ended entitlement basis for costs of maintaining children in foster care, whose biological families are eligible for Aid to Families with Dependent Children (AFDC), and for related administrative, child placement, and training costs. The federal matching rate is the state's Medicaid rate, which varies according to state per capita income. Foster care may be provided in homes or institutions and must meet certain requirements. Eligible administrative and child placement costs are matched at 50%, and the federal matching rate for training is 75%. *FY1996 funding*: $3.7 billion. *FY1997 Administration request*: $3.8 billion.

Adoption Assistance (Title IV-E). Authorizes federal matching funds on a permanent basis to states to provide adoption assistance to parents who adopt children with special needs and are eligible for Supplemental Security Income (SSI) or AFDC. Federal matching is available on an open-ended entitlement basis for adoption assistance and for related administrative, child placement, and training costs. Matching rates are the same as under foster care. *FY1996 funding*: $510 million. *FY1997 Administration request*: $568 million.

Independent Living (Title IV-E). Authorizes grants to states for services to older foster children to help them make the transition to life on their own. The program is permanently authorized as a capped entitlement to states. State allocations are based on each state's share of title IV-E foster children in FY1994 and states must provide a 50% match for their share of the first $45 million in federal appropriations. *FY1996 funding*: $70 million. *FY1997 Administration request*: $70 million.

Non-Social Security Act Programs

Authorization of appropriations for the following programs, under the jurisdiction of the House Economic and Educational Opportunities Committee and Senate Labor and Human Resources Committee, expired at the end of FY1995:

Abandoned Infants Assistance Act. Authorizes discretionary grants to states for activities related to babies who have been abandoned by their biological families, particularly infants with AIDS. The program funds foster parent training, and provides residential centers for these children and their natural, foster and adoptive families. *FY1996 funding*: $12 million. *FY1997 Administration request*: $14 million.

Adoption Opportunities Act. Authorizes discretionary funding for a range of adoption activities including facilitating the adoption of special needs children and providing post legal-adoption services. *FY1996 funding*: $12 million. *FY1997 Administration request*: this program would be consolidated with child welfare research and training, and CAPTA discretionary activities to form a new Child Welfare Innovative Program, to be funded at the programs' combined funding level in FY1995 ($39 million).

Child Abuse Prevention and Treatment Act state grants. Authorizes grants to help states improve their child protective service systems. As a condition of funding, requires states to establish mandatory child abuse and neglect reporting systems. *FY1996 funding*: $21 million. *FY1997 Administration request*: $23 million.

Community-Based Family Resource Centers. Grants for community-based family resource centers are authorized under CAPTA. *FY1996 funding*: $23 million. *FY1997 Administration request*: $50 million for consolidation of community-based family resource center grants, temporary child care and crisis nurseries, and family support centers authorized under the McKinney Act.

Child Abuse Prevention and Treatment Act discretionary grants. Authorizes research and demonstration activities. *FY1996 funding:* $14 million. *FY1997 Administration request:* this program would be consolidated with adoption opportunities and child welfare research and training to form a new Child Welfare Innovative Program, to be funded at the programs' combined funding level in FY1995 ($39 million).

Temporary Child Care for Children with Disabilities and Crisis Nurseries Act. Authorizes state demonstration grants for: temporary nonmedical child care (respite care) for children with special needs to alleviate stress among children and their families; and crisis nurseries to provide short-term care for abused and neglected children or those at risk of abuse. *FY1996 funding*: $10 million. *FY1997 Administration request*: included in funding requested for consolidation of community-based family

resource center grants, temporary child care and crisis nurseries, and family support centers (see above).

Welfare Reform in the House

Lawmakers and policy analysts have debated for decades the relative merits of categorical programs versus block grants as the most appropriate vehicle for federal support of social services programs. Early in the 104th Congress, the House Republican leadership and a group of Republican Governors developed block grant proposals to replace potentially hundreds of existing programs. The House-passed welfare reform bill contains five proposed block grants, including the Child Protection Block Grant.

The Child Protection Block Grant

Legislative History. The history of the Child Protection Block Grant, as contained in the welfare reform bill passed by the House on March 24, 1995, is somewhat complex. First, the Personal Responsibility Act as originally contained in the Contract with America, which included no significant child welfare amendments, was introduced on January 4, 1995, as H.R. 4. When H.R. 4 was passed by the House, it was dramatically different from the original version. The House-passed bill included a block grant to replace AFDC, a Child Protection Block Grant, a child care block grant, two child nutrition block grants, restrictions on alien eligibility for federal programs, and amendments to the food stamp program, Supplemental Security Income, and child support enforcement.

Programs To Be Replaced. As contained in the House-passed H.R. 4, the following programs now authorized under the Social Security Act would be repealed and replaced by the proposed Child Protection Block Grant: child welfare services under Title IV-B; family preservation and family support under Title IV-B; grants to states for foster care and related administration, child placement and training costs under Title IV-E; grants to states for adoption assistance and related administration, child placement and training costs under Title IV-E; and independent living under Title IV-E.

In addition, the following programs would be repealed and replaced by the CPBG: abandoned infants assistance; adoption opportunities; activities under CAPTA; the crisis nurseries portion of the temporary child care and crisis nurseries program; family support centers under the Stewart McKinney Homeless Assistance Act; grants to improve investigation and prosecution of child abuse cases and children's advocacy centers, under the Victims of Child Abuse Act; and the family unification program under Section 8 of the Housing Act. In addition, the Missing Children's Assistance Act would be repealed, although $7 million would be authorized separately in the legislation to fund similar activities to those authorized by this Act (i.e., an information clearinghouse and telephone hotline for information on missing and runaway children).

The family violence prevention and treatment program, which had been considered for inclusion in the block grant, was not repealed by the Opportunities Committee and was reauthorized last year through FY2000. However, certain provisions in H.R. 4, most notably the state allocation formula, appear to assume inclusion of this program.

Authorization and Funding. The Child Protection Block Grant would be authorized under Title IV-B of the Social Security Act for 5 years as a capped entitlement to states; i.e., states would be entitled to their share of a nationwide ceiling or "cap." The ceiling amounts are: $3.9 billion in FY1996; $4.2 billion in FY1997; $4.5 billion in FY1998; $4.8 billion in FY1999; and $5.1 billion in FY2000. These amounts are based on Congressional Budget Office (CBO) projections of spending that would occur during the 5 years under entitlement programs that are proposed to be replaced, if no changes were made in current law. CBO's projected increases due to inflation, however, are not included in these proposed funding levels. An additional $486 million annually would be authorized to be appropriated for the CPBG; these amounts are intended to equal the FY1994 funding level of discretionary programs that are assumed to be replaced by the block grant.

H.R. 4 would base state allocations on each state's relative share of funds received either during FYs 1992-1994 or in FY1994 only, whichever is greater, under the following programs: foster care and adoption assistance under Title IV-E of the Social Security Act, the Family Violence Prevention and Services Act, CAPTA state grants, community-based family resource programs under CAPTA, and child welfare services under Title IV-B of the Social Security Act.

During FYs 1996 and 1997, states would be required to maintain their FY1995 level of spending of non-federal funds under Titles IV-B and IV-E of the Social Security Act. During FY1998-FY2000, states would be allowed to transfer up to 30% of Child Protection Block Grant funds for use under other designated block grant programs.

Program Purposes. The purposes of the new block grant would be similar to purposes of programs proposed to be repealed. Specifically, the purposes would be to: identify and assist families at risk of abusing or neglecting their children; operate a system for receiving reports of child abuse or neglect; investigate families reported to abuse or neglect their children; provide support, treatment or family preservation services to families that abuse or neglect their children, or are at risk of doing so; support children who must be removed from their families; make timely decisions about permanent arrangements for children who cannot return to their families; and provide for continuing evaluation and improvement of child protection laws, regulations and services. Allowable activities would be anything intended to accomplish these purposes.

Program Requirements. To receive allocations, states would submit a plan every 3 years outlining their child protection program, and certifying that the state had a law requiring reporting of child abuse or neglect; a program to investigate child abuse and neglect; procedures for removal and placement of abused or neglected children; and procedures for a written permanency plan for each child removed from home that would be reviewed every 6 months. States would be required to honor any adoption assistance agreements in effect when the new program took effect, and to have an independent living program for older foster children. States also would certify that they had procedures to respond to reports of medical neglect of disabled infants, and would have to declare quantifiable child welfare goals.

In addition, the following standards would apply: the primary standard by which a child welfare system would be judged is the protection of children; states must investigate child abuse and neglect reports promptly; children removed from their homes must have a permanency plan and dispositional hearing within 3 months of a

fact-finding hearing; and all child welfare cases with an out-of-home placement must be reviewed every 6 months, unless the child is in a long-term placement.

States receiving block grant funds would be required to establish at least 3 citizen review panels whose members would be representative of the community. These panels would meet at least quarterly and would review child welfare cases to determine whether agencies receiving block grant funds are acting in accordance with the state plan and standards described above, and are meeting any other criteria considered important by the panel. These panels would have access to any information necessary to conduct their reviews, and would produce a public report after each meeting.

The Secretary of HHS would administer the CPBG and determine whether state plans contain required information. However, the Secretary could not require additional information to be included in the state plan or review the adequacy of state procedures. State spending of block grant funds would be audited every 2 years to determine whether funds are used only for allowable activities and to determine, for FYs 1996 and 1997, whether the state maintenance-of-effort requirement is being met. The Secretary would withhold any misspent funds from future allocations, up to 25% of a state's quarterly allocation. In addition, states would be required to submit annual reports, and could be penalized if reports were not submitted on time. Beyond these penalty provisions, the Secretary would be prohibited from regulating the conduct of states or enforcing any provision of the legislation.

Reporting Requirements. As stated above, states would submit annual statistical reports containing the following: number of children reported to be abused or neglected; the number of such reports that were substantiated; of substantiated reports, the number where no services were provided, the number that did receive services, and the number of children removed from their families; the number of families that received preventive services; the number of children who entered and exited foster care; types of foster care placements and number of children in each type; average length of stay in foster care; age, ethnicity, gender and family income of foster children; number of foster children with a goal of adoption; number of foster children freed for adoption; number of former foster children whose adoptions were finalized; number of disrupted adoptions; number of abandoned infants, including the number who were adopted and the length of time between abandonment and adoption; number of foster children who died and number of children who died as a result of abuse or neglect; and number of children served in the independent living program.

States also report include quantitative measures showing progress toward child welfare goals; responses to findings and recommendations of citizen review panels; and any other information agreed to by the Secretary and a majority of states. The Secretary would prepare an annual report on information submitted by states. H.R. 4 also contains the following separate authorizations for the Secretary: $6 million in entitlement funds annually for FYs 1996-2000 to conduct a national random sample study of child welfare, which would include a longitudinal component; and $10 million annually for child welfare research and training. In addition, $7 million would be authorized for the Attorney General to operate an information clearinghouse and telephone hotline on missing or runaway children.

Multiethnic Adoptions. The 103rd Congress enacted legislation that prohibits denial or delay of foster or adoptive placements on the basis of race (Metzenbaum

Multi-Ethnic Placement Act, P.L. 103-382, Section 551 *et seq.*). However, under P.L. 103-82, agencies may consider as one of a number of factors the race or ethnicity of a child and the capacity of prospective foster or adoptive parents to meet the needs of the child. The House welfare reform bill would repeal the Metzenbaum Act and prohibit agencies receiving federal assistance from denying or delaying foster or adoptive placement of a child because of the prospective parents' race.

Welfare Reform in the Senate

The Senate took a different approach to child abuse and child welfare issues in the 104th Congress. The Senate version of H.R. 4, called the Work Opportunity Act, was passed on September 19 and would replace AFDC with a block grant to states, as in the House bill. However, the Senate bill would not include a block grant for child welfare programs. Instead, child welfare programs under the Social Security Act would remain untouched, and CAPTA and related expiring programs would be reauthorized.

Reauthorization of Expiring Programs

CAPTA. The Senate-passed bill would reauthorize CAPTA through FY2000. The legislation would repeal the temporary child care and crisis nurseries program and family support centers under the McKinney Homeless Assistance Act, and would consolidate these activities in an expanded Community-Based Family Resource and Support Program under CAPTA. For Title I of CAPTA (the state grant program and research and other discretionary activities), $100 million would be authorized in FY1996 and such sums as necessary thereafter. For Title II (the expanded Community-Based Family Resource and Support Program), $108 million would be authorized for each of FYs 1997-2000.

The Senate bill would amend CAPTA to give the Secretary of HHS greater discretion in administration of child abuse activities. The mandatory National Center on Child Abuse and Neglect would be eliminated, and the Secretary could administer CAPTA through another entity within HHS, including a separate Office on Child Abuse and Neglect. Likewise, the Secretary would have the option, rather than the mandate, of establishing an Advisory Board on Child Abuse and Neglect. Additional amendments would attempt to improve child abuse data collection and promote coordinated data collection with the child welfare system, and would focus research projects on the issues of unsubstantiated abuse and neglect reports, abuse within foster care, and abuse allegations in domestic disputes. Several new demonstrations would be authorized, including the following: collaboration with community agencies to develop a triage system for screening and assessing abuse and neglect reports; establishment of kinship care procedures using adult relatives as the preferred placement for children removed from home, when appropriate; and establishment of supervised visitation centers in cases where domestic violence causes ongoing risk to a parent or child.

The Senate-passed bill also would streamline and simplify eligibility requirements and program plan components for the state grant program under CAPTA. Under current law, states must have in effect a state law providing for mandatory child abuse and neglect reporting and immunity from prosecution for reporters of abuse or neglect. The amendments would allow states to have either a law or a program covering these issues. The amendments further revise provisions related to medical neglect, and would

require states (within 2 years of enactment) to develop procedures for appealing findings of abuse or neglect.

Related Programs. In addition to CAPTA, the Senate welfare reform package would reauthorize several related programs. The Senate proposal would reauthorize the Abandoned Infants Assistance Act through FY2000 at an authorization level of $35 million in FY1996, and such sums as necessary thereafter. The adoption opportunities program would be reauthorized through FY2000 under the Senate bill at $20 million in FY1996 and such sums as necessary thereafter.

Further, the Senate bill would reauthorize the Missing Children's Assistance Act through FY1997; would extend children's advocacy centers under the Victims of Child Abuse Act through FY1997; and would reauthorize grants to improve criminal prosecution of child abuse and neglect cases, authorized under the Victims of Child Abuse Act, through FY2000.

Foster Care Eligibility

Because the Senate bill would repeal AFDC and replace it with a block grant to states, the bill also makes technical amendments to foster care and adoption assistance under Title IV-E of the Social Security Act, which would continue to operate as open-ended entitlements. Under current law, states may claim reimbursement under Title IV-E for children who would otherwise be eligible for AFDC. Under the Senate proposal, states would be able to claim reimbursement under Title IV-E for children *who would have been* eligible for AFDC, as it was in effect on June 1, 1995.

Grandparent Caregivers

The Senate bill also has provisions related to grandparents who are primary caregivers for their grandchildren, an arrangement often referred to as kinship care. Specifically, the legislation would require the Census Bureau to collect statistically significant data, in connection with the decennial and mid-decade census, on grandparents who are the primary caregivers for their grandchildren. Such data would distinguish between households in which a grandparent temporarily provides a home for their grandchild during a short-term period of parental distress, and households in which the grandparent provides a home and serves as the grandchild's primary caregiver.

In addition, the bill would require the Secretary of HHS to conduct a study on the impact of the welfare reform legislation on grandparents who have assumed responsibility for their grandchildren. The Secretary would identify any barriers to participation experienced by such grandparents in public programs including Medicaid, cash welfare assistance, child support enforcement and foster care. The Secretary would be required to report findings of this study to Congress no later than December 31, 1997, and to make recommendations for any appropriate legislative or administrative changes.

Conference Committee Agreements

On December 21 and 22, the House and Senate passed a House-Senate conference agreement on omnibus welfare reform legislation (H.R. 4, H.Rept. 104-430). Earlier,

Congress had incorporated a similar but not identical version of welfare reform budget reconciliation legislation (H.R. 2491), which was vetoed by President Clinton on December 6. The following describes the conference agreement on H.R. 4, the free-standing welfare reform bill, which was vetoed by President Clinton on January 9, 1996.

Child Protection Block Grant. The conference agreement on H.R. 4 would repeal the following programs currently authorized under Titles IV-B or IV-E of the Social Security Act, and replace them with a single block grant to states: child welfare services, family preservation and family support services, independent living services, and administrative and training expenses associated with foster care and adoption assistance. (Administrative and training expenses currently are reimbursed as an open-ended entitlement to states.) The new block grant would begin in FY1997 and be structured as a capped entitlement to states, with an annual ceiling set at $2 billion in FY1997 and rising to $2.8 billion in FY2002. In addition, $325 million annually in discretionary funds would be authorized. State allotments would be based on federal payments to states under the programs to be replaced either in FY1994, or the average of FY1992-FY1994, if higher. States would not have to match these block grant allotments but would be required to maintain 100% of their FY1994 level of nonfederal expenditures for programs to be replaced in FYs 1997 and 1988, and 75% of such level in FY1999-2002.

Foster Care and Adoption Assistance Payments. In addition to their Child Protection Block Grant allotments, states would be authorized under H.R. 4 to claim federal reimbursement, on an open-ended entitlement basis, for foster care maintenance and adoption assistance payments under the same terms and conditions as currently in effect under Title IV-E of the Social Security Act. (Note: *administrative costs* related to foster care and adoption assistance would be eliminated and replaced by the block grant described above; however, *maintenance payments* for foster care and adoption assistance would continue as open-ended entitlements.) Under current law, children must be eligible for AFDC in order to be eligible for federal foster care payments. Because other provisions of the welfare agreement in H.R. 4 would repeal AFDC, the legislation would require states to use their current AFDC income standards, adjusted for inflation in accordance with federally issued regulations, for purposes of determining federal foster care eligibility.

Child and Family Services Block Grant. H.R. 4 would create a second block grant to states that would replace the Child Abuse Prevention and Treatment Act and the following programs: adoption opportunities, abandoned infants, temporary child care and crisis nurseries, and family support centers under the McKinney Homeless Assistance Act. This block grant would begin in FY1996. For FY1996, $230 million in discretionary funds would be authorized, and such sums as necessary for FY1997-FY2002. Of annual appropriations, 12% would be reserved for the Secretary of HHS to conduct research, demonstration, training and technical assistance. Remaining block grant funds would be allocated to states according to their relative populations of children under the age of 18.

Child Protection Requirements. To receive funds under either block grant, states would be required to submit a plan that, among other things, would certify that the state has the following: a mandatory child abuse and neglect reporting law; procedures for responding to abuse and neglect reports; procedures for removing

children from abusive or neglectful homes; laws providing immunity from prosecution for good faith reports of abuse or neglect; laws and procedures to expunge certain records in cases found to be unsubstantiated or false; laws and procedures (within 2 years of enactment) to enable individuals to appeal official findings of child abuse or neglect; permanency planning procedures for foster children; independent living services for older foster children; procedures to respond to reports of medical neglect of disabled infants; and procedures for confidentiality and prompt disclosure of information.

States also would be required to establish quantitative child protection goals and to certify that they are in compliance with specific child protection standards, which are the same standards generally referred to as the "section 427 protections" in current law. Further, states would be required to make reasonable efforts to avoid the need to place children in foster care and to reunite them with their families, as in current law, and also would be required to provide services or refer for services families and children where abuse or neglect has been confirmed but the state has determined that the child may remain safely with the family.

Monitoring and Enforcement. Under the conference agreement on H.R. 4, state compliance with federal child protection requirements would be measured and enforced through audits and imposition of penalties for misspent funds. In addition, section 1123 of the Social Security Act, which would remain in effect, requires HHS to establish through regulation a new conformity review system for child welfare, which would require corrective action plans and allow penalties for misuse of funds, effective April 1996. The agreement also would require states to submit detailed statistical reports to HHS and would impose penalties on states for failure to submit such reports on time. Finally, states would be required to establish at least three citizen review panels to review child welfare cases and determine compliance with the federally required state plan, child protection standards, and other criteria chosen by the panel. Panels would produce public reports, and states would respond in their annual statistical reports to panel findings and recommendations.

Data Collection, Research, and Court Improvement Grants. States would be required to submit case-specific data, twice a year, on children served by their child protection, foster care, and adoption assistance programs. States also would be required to submit annual aggregate data on their programs, including data on child abuse and neglect within the state. In addition, beginning 3 years after enactment, states would submit annual reports showing quantitative progress toward their child protection goals.

As stated above, HHS would receive 12% of appropriations under the Child and Family Services Block Grant to conduct research, demonstration, training and technical assistance. Of this amount, 40% would be used for demonstrations. HHS would be required to continue funding a national clearinghouse for information related to child abuse, and would have the option of appointing an advisory board on child abuse and neglect.

Further, H.R. 4 would authorize and appropriate $6 million each year during FY1996-FY2002 for the Secretary to conduct a national random sample study of child welfare, and another $10 million in mandatory funding each year for additional research. Finally, the conference agreement would authorize and appropriate $10

million in FY1996-FY1998 for the Secretary to continue an existing program of grants to state courts for improvements in their child welfare proceedings.

Multiethnic Adoptions. The conference agreement on H.R. 4 adopted the provisions related to interethnic adoptions contained in the House version of H.R. 4, which would repeal the Metzenbaum Act and prohibit agencies receiving federal assistance from denying or delaying foster or adoptive placement of a child because of the prospective parents' race.

Program Reauthorizations. The conference agreement on H.R. 4 would reauthorize the Missing Children's Assistance Act, and grants for improvement of prosecution and investigation of child abuse cases and children's advocacy centers under the Victims of Child Abuse Act, through FY1997.

The "Appropriate" Federal Role

Proposals to block grant child welfare programs ultimately lead to discussions of the appropriate federal role in child welfare. It could be argued that child welfare is an area governed by state policy and state laws and that the appropriate federal role is to provide financial support to states to help them develop and operate effective child protection systems. It could further be argued that federal financial support should have as few strings as possible, since the issues facing child welfare agencies vary among and within states and, therefore, states need flexibility to develop policy, enact laws, and design programs that best meet their unique and changing needs. Advocates of this position might also argue that states, ultimately, are responsible for children in their legal custody and should be trusted to protect these children without federal mandates.

On the other hand, proponents of a strong federal role in child welfare could argue that federal mandates are responsible for many of the reforms of the past 20 years, such as mandatory child abuse and neglect reporting systems, judicial review of decisions to remove children from their homes, tracking systems for children in foster care, permanency planning and case reviews for foster children, licensing of foster homes and institutions, and incentives for parents to adopt children with special needs.

Advocates of the current federal role in child welfare would recall the concerns that led to enactment of landmark legislation in 1980 (the Adoption Assistance and Child Welfare Act, P.L. 96-272). The debate that preceded that legislation suggested that children were languishing in foster care, that many children were unnecessarily removed from their homes and no efforts were made to reunify families or encourage visitation, and that preventive services and alternatives to foster care were not explored. There was concern that social worker caseloads were too large, that children got lost in the system, that no written case plans or periodic reviews were conducted, and that no data were collected to monitor children in foster care. In addition, the pool of adoptable children was changing to include a greater proportion of older, minority or disabled children, as well as children in sibling groups, and one of the barriers cited to adoption of these children was a lack of financial support for adoptive parents.

On the other hand, advocates of a reduced federal role might argue that the 1980 legislation has not fully achieved its goals, and could point to the current crisis in many

state child welfare agencies as evidence that federal mandates are not a solution for vulnerable children and families. Others would maintain that the reforms mandated in P.L. 96-272 had only begun to yield positive results when the unanticipated crack cocaine epidemic overwhelmed the resources of state and local agencies, beginning in the mid-1980s. These observers would argue that more federal resources are needed, targeted toward activities such as preventive services and substance abuse treatment.

Specific controversy surrounds the federal mandates in CAPTA governing state child abuse and neglect reporting laws, prompt investigation of reports, immunity for reporters of abuse and neglect, and confidentiality of records. Advocates of a reduced federal role argue that these mandates result in overzealousness by state and local agencies fearful of losing federal funds, and divert resources from more serious abuse and neglect cases. Others maintain that federal mandates are necessary to assure a minimum level of protection for children in all states. Advocates of both positions can cite specific examples of children and families who have either been hurt or helped by federal policy and its implementation at the state level.

LEGISLATION

H.R. 4 (Shaw)

Personal Responsibility Act. Contract with America bill. Introduced January 4, 1995. Ways and Means Subcommittee on February 15 approved alternative legislation to create block grants to replace AFDC and child welfare-related programs. (See H.R. 1157 and H.R. 1214 for further action.) Passed by the House on March 24, with the language of H.R. 1214 inserted. Substitute version reported by Senate Finance Committee on June 9 (S.Rept. 104-96). Modified version of Senate Finance bill incorporated into Republican leadership welfare reform bill (see S. 1120, below), which was further modified, amended, and passed by the full Senate on September 19. Conference agreement (H.Rept. 104-430) filed on December 20; passed by the House December 21 and by the Senate on December 22. Vetoed by President Clinton on January 9, 1996.

H.R. 11 (Vucanovich)

Family Reinforcement Act. Contract with America bill: establishes refundable tax credit for up to $5000 for adoption expenses. Introduced January 4, 1995. Incorporated into H.R. 1215 (see H.R. 1215 for further action).

H.R. 586 (Maloney)

Omnibus Foster Care Improvement Act. Amends Title IV-E. Introduced January 19, 1995; referred to Ways and Means.

H.R. 709 (Maloney)

Standby Guardianship Act. Amends Title IV-E to allow chronically ill or dying parents to name a standby guardian for minor children without relinquishing parental rights. Introduced January 26, 1995; referred to Ways and Means.

H.R. 999 (Goodling)

Welfare Reform Consolidation Act. Repeals child abuse and related programs that would be replaced by child protection block grant created by Ways and Means (see H.R.

4, H.R. 1157 and H.R. 1214). Introduced February 21, 1995; ordered reported by Opportunities Committee on February 23 (H.Rept. 104-75, Part 1).

H.R. 1044 (Fawell)

At-Birth Abandoned Baby Act. Amends title IV-E to prevent abandoned infants from experiencing prolonged foster care. Introduced February 24, 1995; referred to House Committee on Ways and Means.

H.R. 1157 (Archer)

Welfare Transformation Act. Creates block grants to replace AFDC and child welfare programs, among other provisions. Introduced and ordered reported by House Ways and Means Committee on March 8, 1995. Report filed on March 15 (H.Rept. 104-81, Part 1). (See H.R. 1214 and H.R. 4 for further action.)

H.R. 1214 (Archer, Goodling, Roberts)

Personal Responsibility Act. Omnibus welfare reform package (includes provisions of H.R. 999 and H.R. 1157). Introduced March 13, 1995. Language inserted into H.R. 4, which passed House on March 24.

H.R. 1215 (Archer)

Contract with America Tax Relief Act. Includes adoption tax credit proposal from H.R. 11. Introduced March 13, 1995; reported by Ways and Means March 21 (H.Rept. 104-84). Passed House on April 5; referred to Senate Finance Committee.

H.R. 1263 (Payne)

Abandoned and Medically Fragile Infants Assistance Act. Introduced March 16, 1995; referred to the House Economic and Educational Opportunities Committee.

H.R. 2127 (Porter)

FY1996 Labor-Health and Human Services-Education Departments Appropriations Act. Contains FY1996 appropriations for child abuse, child welfare, foster care, adoption assistance and related programs. Reported by House Appropriations Committee on July 27 (H.Rept. 104-209). Passed the House on August 4, 1995. Reported by Senate Appropriations Committee on September 15 (S.Rept. 104-145).

H.R. 2387 (Wyden)

Amends Title IV-E of the Social Security Act to promote kinship care, and to authorize kinship care demonstrations. Introduced September 21; referred to House Ways and Means Committee.

H.R. 2491 (Kasich)

Seven-Year Balanced Budget Reconciliation Act. Includes welfare reform provisions. Passed House October 26; passed Senate (in lieu of S. 1357) October 28. Conference agreement (H.Rept. 104-350) passed House November 17 and passed Senate November 20. Vetoed by President Clinton on December 6.

S. 637 (McCain)

Adoption Anti-Discrimination Act. Introduced March 28, 1995; referred to Senate Finance Committee.

S. 919 (Coats)

Child Abuse Prevention and Treatment Act Amendments. Reauthorizes CAPTA and related programs through FY2000. Introduced June 13, 1995; reported by Senate Labor and Human Resources Committee on June 21 (S.Rept. 104-117). Provisions incorporated into modified amendment 2280 to H.R. 4 on August 11, which passed Senate September 19, 1995 (see S. 1120, below, for chronology).

S. 1117 (Daschle)

Work First Act of 1995. Senate Democratic leadership welfare reform bill. Introduced on August 3, and offered on August 8 with 30 co-sponsors as amendment number 2282 to H.R. 4. Modifications made on August 11. During debate on H.R. 4, this amendment was defeated.

S. 1120 (Dole)

Work Opportunity Act of 1995. Senate Republican leadership welfare reform bill. Introduced August 3; offered August 5 with 36 co-sponsors as amendment 2280 to H.R. 4. Further modified on August 11, including incorporation of the language of S. 919 (see above). Passed Senate September 19 as amendment to H.R. 4.

S. 1201 (Coats)

Kinship Care Act of 1995. Authorizes kinship care demonstrations. Introduced September 6; referred to Senate Labor and Human Resources Committee.

FOR ADDITIONAL READING

U.S. House of Representatives. Committee on Ways and Means. *The Green Book: Overview of Entitlement Programs,* Section 14. WMCP 103-27, July 15, 1994.

U.S. Library of Congress. Congressional Research Service. *Appropriations for FY1996: Labor, Health and Human Services, and Education*, by Paul Irwin. Regularly updated, 32 pp.
CRS Report 95-633

----- *Child Protection in House and Senate Welfare Reform Bills*, by Karen Spar. October 25, 1995.
CRS Report 95-1066 EPW

----- *Child Protection Provisions in Welfare Reform, H.R. 4,* by Karen Spar. December 21, 1995.
CRS Report 95-1154

----- *Orphanages: A New Issue in Welfare Reform,* by Karen Spar. December 8, 1994.
CRS Report 94-986 EPW

----- *Welfare Reform,* by Vee Burke. (Regularly updated.)
CRS Issue Brief 93034

----- *Welfare Reform: Implications of H.R. 4 for Child Welfare Services*, by Karen Spar. May 3, 1995.
CRS Report 95-566

----- *Welfare Reform: The House-Passed Bill (H.R. 4)*, by Vee Burke, Joe Richardson, Carmen Solomon, Karen Spar, and Joyce Vialet. April 5, 1995.
CRS Report 95-375 EPW

----- *Welfare Reform: The Senate-Passed Bill (H.R. 4)*, by Vee Burke, Joe Richardson, Carmen Solomon, Karen Spar, Joyce Vialet, Louis A. Talley, and Larry Eig. September 29, 1995.
CRS Report 95-991 EPW