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REFORMING CHILD PROTECTION:  
A PUBLIC HEALTH PERSPECTIVE

**Marsha Garrison, J.D.\***

I. INTRODUCTION

A quarter of a century ago, researchers and reformers reported that the results achieved by the child protection system were far removed from its goals. While child protection services were theoretically tailored to each family's needs, out-of-home placement was virtually the only alternative actually offered. And while out-of-home placement was theoretically a planned, temporary period of parental rehabilitation, many foster children remained in state care throughout childhood, subject to unstable placements and deteriorating relationships with their biological families.<sup>1</sup>

The problems were obvious; the solutions seemed obvious, too. Child protection experts and national panels universally recommended a three-prong reform program, urging that public authorities should: 1) not place a child in foster care unless her parents were so inadequate that the problems were impossible to resolve in the home; 2) if foster care was required, work seriously and intensively toward family reunification for a planned period; and, 3) if reunification efforts failed, terminate the parent's rights and place the child in a stable adoptive home.<sup>2</sup>

The reform program was a legislative success. In 1980, Congress adopted the Adoption Assistance and Child Welfare Act (AACWA), which required the states, as a condition of federal foster care funding, to make "reasonable [pre-placement] efforts" to solve the child maltreatment problem at home, provide periodic case review, and offer services to reunite children with their parents or ensure that they are

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<sup>1</sup> Although the "discovery" of problems within the child welfare system dates from the 1970s, research reports documenting those problems had been produced much earlier. See, e.g., HENRY MAAS & RICHARD ENGLER, CHILDREN IN NEED OF PARENTS 349-52 (1959).

<sup>2</sup> See Marsha Garrison, *Child Welfare Decisionmaking: In Search of the Least Drastic Alternative*, 75 GEO. L.J. 1745, 1758-60 (1987) [hereinafter *Child Welfare Decisionmaking*] (describing the reform program in general and specific sources).

placed in another permanent home.<sup>3</sup> Many states instituted similar legislative reforms. During the 1980s, these new enactments, particularly the AACWA, produced a series of lawsuits aimed at the transformation of state and local child welfare systems.<sup>4</sup>

Unfortunately, the reform program was not a programmatic success: neither the new laws nor the lawsuits produced the changes in practice that reformers had hoped to achieve.<sup>5</sup> The foster care population did not decline; instead, the number of children in care almost doubled<sup>6</sup> as entries into care skyrocketed and reunification rates declined.<sup>7</sup>

Confronted with this dismal record, policy makers have in recent years initiated new reforms, most notably the federal Adoption and Safe Families Act (ASFA). In order to curb growth of the foster care population, ASFA mandates parental rights termination if a child has been in state care for fifteen of the past twenty-two months. In some

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<sup>3</sup> Pub. L. No. 96-272, 94 Stat. 500 (codified as 42 U.S.C. §§ 671(a)(15)-(16), 672(a)(1)-(2), 675(5)(B)).

<sup>4</sup> Before the Supreme Court's decision in *Suter v. Artist M.*, 503 U.S. 347, 364 (1992), holding that the AACWA does not confer on its intended beneficiaries a private right that is enforceable in a 42 U.S.C. § 1983 action, law reform actions based on the AACWA were brought in many parts of the country. *LaShawn v. Dixon*, 762 F. Supp. 959, 987 (D.D.C. 1991); *Del A. v. Edwards*, 855 F.2d 1148, 1150 (5th Cir. 1988).

<sup>5</sup> For example, in *LaShawn v. Dixon*, 762 F. Supp. at 989-990, a federal district court ruled that the District of Columbia Department of Human Services had consistently evaded its responsibilities under federal law. After the District Court's findings were upheld on appeal in *LaShawn v. Kelly*, 990 F.2d 1319 (D.C. Cir. 1993), the district court judge, as part of a settlement, took control of a large part of the District's foster care system and announced that he was appointing the Center for the Study of Social Policy as a monitor to ensure that the District complied with strict deadlines concerning improved staffing and procedures, reducing the backlog of children in foster care, and establishing a procedure for reviewing the deaths of children in its care. In a later order, the judge extended the receivership order to child protective services as well as foster care. Tony Locy, *Court Tightens Grip on D.C. Foster Care; Services for At-Risk Children to be Overseen by Outside Team*, WASHINGTON POST, Nov. 19, 1994, at B1. But in 2000, the federal General Accounting Office issued a report concluding that the receivership had failed to alter the staffing and caseload patterns that had produced the original lawsuit. See U.S. GEN. ACCT. OFF., DISTRICT OF COLUMBIA CHILD WELFARE: LONG-TERM CHALLENGES TO ENSURING CHILDREN'S WELL-BEING, No. 01-191 (2000).

<sup>6</sup> Between 1984 and 1996, the U.S. foster care population rose from 276,000 children to 502,000 children. Robert M. Gordon, *Drifting Through Byzantium: The Promise and Failure of the Adoption and Safe Families Act of 1997*, 83 MINN. L. REV. 637, 650 n.73 (1999).

<sup>7</sup> See Fred Wulczin, *Family Reunification*, in 14 THE FUTURE OF CHILDREN: CHILDREN, FAMILIES, AND FOSTER CARE 95, 103-04 (Winter 2004) (reporting a thirteen percent slower reunification rate for those who entered system in 1997 as compared to those who entered in 1990).

cases, it also frees child welfare workers from reunification efforts.<sup>8</sup> ASFA thus represents a tacit admission that curing family dysfunction is not easy; it relies exclusively on adoption to curb the human and public costs of prolonged foster care.

While ASFA does seem to have increased the number of adoptions from foster care,<sup>9</sup> it has simultaneously increased the “backlog” of foster children awaiting adoption.<sup>10</sup> Some experts have questioned whether adoptive homes can ever be found for all of these children,<sup>11</sup> many of whom are not healthy, readily adoptable, white infants. Nationally, forty-two percent of children awaiting adoption from foster care are African-American, more than two-thirds are age six or older,<sup>12</sup> and a

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<sup>8</sup> Under ASFA, reasonable efforts at reunification need not be made: (1) if the parent has subjected the child to “aggravated circumstances,” as defined by state law; (2) if the parent has committed or aided in, conspired in, or attempted the commission of murder or voluntary manslaughter of another of that parent’s children, or has committed a felony assault resulting in serious bodily injury to the child or another child of the parent; and (3) if the parent’s rights have been terminated with regard to a sibling of the child whose case is proceeding. 42 U.S.C. § 671(a)(15)(D) (2005). ASFA also requires that states file a petition to terminate the parental rights of the parent(s) of any child who has been in foster care for fifteen of the most recent twenty-two months and shortened the time frame within which states must schedule a permanency hearing. For children whose parents are not entitled to reasonable efforts, ASFA requires a permanency hearing within thirty days. For others the time frame was shortened from eighteen to twelve months from the time a child enters foster care; an exception is provided in cases where parents have not received services required by the reasonable efforts clause. 42 U.S.C. §§ 675(5)(C), (E) (2005). ASFA also created an adoption incentive program by which states will receive \$4,000 to \$6,000 per child for any increase in the annual number of adoptions over a “baseline” year. 42 U.S.C § 673b(d) (2005).

<sup>9</sup> Nationally, adoptions of children in foster care increased from 47,000 in FY 1999 to 53,000 in FY 2002 but declined to 49,000 in 2003. See U.S. ADMIN. FOR CHILDREN & FAMILIES, U.S. DEPT. OF HEALTH AND HUMAN SERVICES, NATIONAL FOSTER CARE STATISTICS, available at <http://www.acf.hhs.gov/programs/cb/dis/afcars/publications/afcars.htm> [hereinafter NAT’L STATISTICS].

<sup>10</sup> In September, 2002, there were approximately 532,000 children in U.S. foster care. 126,000 of these children were eligible for adoption. NAT’L STATISTICS, *supra* note 9. Among children eligible for adoption, the mean waiting period was twenty five months. *Id.*

<sup>11</sup> See KATHY BARBELL & MADELYN FREUNDLICH, FOSTER CARE TODAY 28 (2001), available at [http://www.casey.org/NR/rdonlyres/89981DE1-D4B8-4136-82DD-DD1C8FDEF7CE/129/casey\\_foster\\_care\\_today.pdf](http://www.casey.org/NR/rdonlyres/89981DE1-D4B8-4136-82DD-DD1C8FDEF7CE/129/casey_foster_care_today.pdf); Celeste Pagano, *Recent Legislation: Adoption and Foster Care*, 36 HARV. J. ON LEGIS. 242, 248 (1999) (arguing that “ASFA will probably produce more orphans”).

<sup>12</sup> See NAT. STATISTICS, *supra* note 10. In 2000, forty-one percent of all U.S. foster children were African-American. See ALFRED PEREZ ET AL., DEMOGRAPHICS OF CHILDREN IN FOSTER CARE 2, available at <http://pewfostercare.org/research/docs/Demographics0903.pdf>. However, in some large, urban foster care systems, the proportion of minority children is much larger. For example, in 1997, seventy-one percent of New York City’s foster care population was African-American,

majority has what are euphemistically described as “special needs.”<sup>13</sup> Given that the American Academy of Pediatrics has estimated children in foster care to have “disproportionately high” rates of severe emotional, behavioral, or developmental problems,<sup>14</sup> special needs typically translate into profound parenting challenges, challenges that many prospective adoptive parents simply do not want to take on.<sup>15</sup> Those who do adopt challenging children may also return them, subjecting these children to yet another form of impermanency.<sup>16</sup> Moreover, while a major increase in adoptions from foster care took place in the years immediately following the enactment of ASFA, since 2000 foster-care adoptions have declined.<sup>17</sup>

In sum, after more than twenty years of state and federal initiatives aimed at bettering the prospects of abused and neglected children, there is no sign that those prospects have significantly improved. Children who enter foster care are at serious risk of remaining there, in unstable and impermanent placements, until adulthood. Neither intensive pre-placement services nor in-placement reunification efforts are currently

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twenty-four percent Hispanic, three percent white, and two percent “other.” See NEW YORK CITY ADMINISTRATION FOR CHILDREN’S SERVICES, OUTCOME & PERFORMANCE INDICATORS 81 (June 1998), available at <http://www.ci.nyc.ny.us/html/acs/pdf/rpindrep.pdf>.

<sup>13</sup> In 2000, only 28% of U.S. foster children were age five or younger. PEREZ ET AL., *supra* note 12, at 1. In 1999, more than 195,000 children received adoption assistance payments designed to support special needs adoptions. Mary Bruce Webb & Brenda Jones Harden, *Beyond Child Protection: Promoting Mental Health for Children and Families in the Child Welfare System*, in 11 J. EMOTIONAL & BEHAV. DISORDERS 45, 52 (Spring 2003) (citing data from CHILDREN’S BUREAU, U.S. DEP’T OF HEALTH & HUMAN SERVICES, FACT SHEET ON ADOPTION (2001)).

<sup>14</sup> See AM. ACAD. PEDIATRICS, DEVELOPMENTAL ISSUES FOR YOUNG CHILDREN IN FOSTER CARE, 106 PEDIATRICS 1145, 1145 (2000).

<sup>15</sup> See U.S. GEN. ACCT. OFF., FOSTER CARE: STATES FOCUSING ON FINDING PERMANENT HOMES FOR CHILDREN, BUT LONG-STANDING BARRIERS REMAIN 15, No. 03-626T (2003) [hereinafter FINDING PERMANENT HOMES] (describing states’ difficulties in finding adoptive homes for special needs children).

<sup>16</sup> See James A. Rosenthal, *Outcomes of Adoption of Children with Special Needs*, in 3 FUTURE OF CHILDREN: ADOPTION 77, 78-84 (Spring 1993) (reporting that, as special needs adoptions increased during 1970s and 1980s, so did rate of disruption; studies report highly disparate findings on disruption rates, ranging from two to fifty-three percent); Richard P. Barth & Marianne Berry, *Outcomes of Child Welfare Services under Permanency Planning*, in 61 SOC. SERV. REV. 71, 76 (1987) (reporting that increased efforts to place former foster children produced increased disruption rate and noting disparate rates of disruption); TRUDY FESTINGER, AFTER ADOPTION: A STUDY OF PLACEMENT STABILITY AND PARENTS’ SERVICE NEEDS (1996), available at [http://childrensrights.org/Policy/policy\\_resources\\_adoption\\_afteradoption.htm](http://childrensrights.org/Policy/policy_resources_adoption_afteradoption.htm).

<sup>17</sup> See NAT. STATISTICS, *supra* note 9.

adequate to provide safe and reliable homes for many children at risk.<sup>18</sup> Adoptive homes are not available for many children who need them.

Increased caseloads have also strained an already overtaxed system to the breaking point. Foster homes are available for less than half of the children who need temporary care, a shortfall that often leads to placement in an institution or with poorly prepared relatives.<sup>19</sup> Staff turnover is high, working conditions are poor, and salaries are low.<sup>20</sup> The pool of experienced, well-trained social workers willing to work in child protection agencies thus continues to decline,<sup>21</sup> with the result that difficult decisions about placement, services, and reunification are all too often left to personnel who are poorly prepared, inexperienced, and overwhelmed.<sup>22</sup>

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<sup>18</sup> See B.D. Perry et al., *Children's Crisis Care Center Model: A Proactive, Multidimensional Child and Family Assessment Process*, Child Trauma Academy Materials, available at [http://www.childtrauma.org/ctamaterials/cccc\\_paper.asp](http://www.childtrauma.org/ctamaterials/cccc_paper.asp) (last visited Mar. 17, 2005).

<sup>19</sup> See ANNIE E. CASEY FOUNDATION, POLICIES AND PRACTICES: SHORTENING CHILDREN'S STAYS IN TEMPORARY CARE 1-2 (2002), <http://www.aecf.org/initiatives/familytofamily/tools/16942.pdf> [hereinafter SHORTENING CHILDREN'S STAYS].

<sup>20</sup> U.S. GEN. ACCT. OFF., HHS COULD PLAY A GREATER ROLE IN HELPING CHILD WELFARE AGENCIES RECRUIT AND RETAIN STAFF 5, 11-18, No. 03-357 (2003) [hereinafter HHS COULD PLAY A GREATER ROLE] (reporting that thirty to forty percent of child welfare positions are estimated to turn over annually and that average job tenure of a U.S. child welfare worker is less than two years and describing pervasive problems with low pay, violence, high caseloads, and administrative burdens that make child welfare work unattractive); ANNIE E. CASEY FOUNDATION, THE UNSOLVED CHALLENGE OF SYSTEM REFORM: THE CONDITION OF THE FRONTLINE HUMAN SERVICES WORKFORCE 9 (2003), available at [http://www.aecf.org/initiatives/hswi/report\\_rev.pdf](http://www.aecf.org/initiatives/hswi/report_rev.pdf) (reporting \$22,000 average starting salary for U.S. child welfare workers).

<sup>21</sup> See PAUL C. LIGHT, BROOKINGS INSTITUTE, THE HEALTH OF THE HUMAN SERVICES WORKFORCE 8 (2003), available at [http://www.aecf.org/initiatives/hswi/cps\\_final.pdf](http://www.aecf.org/initiatives/hswi/cps_final.pdf) (reporting that a significant percentage of recent recruits reported that they intended to leave within the next five years, while recent college graduates showed little serious interest in human services careers); ANNIE E. CASEY FOUNDATION, TROUBLE ON THE HUMAN SERVICES FRONTLINE, THE ADVOCASEY INDEX (Spring 2004), available at [www.aecf.org/publications/advocasey/spring2004/advocasey\\_index.htm](http://www.aecf.org/publications/advocasey/spring2004/advocasey_index.htm). Responding to these pressures, only fifteen percent of U.S. child welfare agencies now require a bachelor or master's degree in social work as an entry credential. See CHILD WELFARE LEAGUE OF AMERICA, MINIMUM EDUCATION REQUIRED BY STATE CHILD WELFARE AGENCIES, PERCENT, BY DEGREE TYPE, 1998, available at [http://ndas.cwla.org/data\\_stats/access/predefined/Report.asp?ReportID=256](http://ndas.cwla.org/data_stats/access/predefined/Report.asp?ReportID=256). These pressures are not confined to the United States. See Raehka Prasad, *Vanishing Workforce: Crisis in the Recruitment and Retention of Care Workers*, THE GUARDIAN, Oct. 17, 2001, at Guardian Society Pages 4 (reporting that in 2001 "overall [U.K.] shortages of . . . staff in some local authorities were as high as 46%").

<sup>22</sup> See HHS COULD PLAY A GREATER ROLE, *supra* note 20, at 3-4.

In Section II, I explore the reasons for this record of failure. I find that reformers relied on assumptions instead of evidence and thereby underestimated the gravity of harm associated with child maltreatment, the difficulty of cure, and the cost of treatment. At a deeper level, I find that the assumptions on which reformers relied derived from a simplistic, anti-authoritarian ideology that cast the state child welfare system as villain and the families served by that system as victims. Because reformers saw the problem as a political failure, they failed to see it as a serious public health problem.

In Sections III and IV, I employ a public health perspective to analyze the problem of child welfare reform and find that a major shift in law, practice, and funding is needed. Despite accumulating evidence that child maltreatment is an urgent public health problem, the child protection system has failed to develop evidence-based treatments or even standardized diagnostic procedures. It has ignored the institutional context in which treatment is delivered, and it has woefully neglected prevention, the key to most successful public health campaigns. Perhaps most importantly, both federal law and local practice have relied on the wrong medical model: law and practice reflect an “acute care” treatment paradigm that aims at rapid cure and exit, while all the evidence suggests that child maltreatment – for both the maltreating parent and the victimized child – is a chronic condition which requires ongoing treatment and services.

## II. THE FAILURE OF CHILD WELFARE POLICY

Why did efforts to reform the child welfare system fail so miserably?

The first important source of failure was reformers’ tendency to focus on the shortcomings of the child protection system instead of the larger problem of child maltreatment. Reformers’ focus was altogether understandable: because of high caseloads and rapid staff turnover, case workers often failed to offer any meaningful assistance to parents or children; because of the bureaucratic emphasis on foster care, case workers also had a relatively small arsenal of services to offer. But this systemic focus made it much too easy to assume that workers with lighter caseloads and a broader array of services could easily and rapidly make a major dent in the population of children in protective placements.

A second source of failure was reliance on preconception instead of empirical data. Reformers responsible for the initiative that produced the AACWA alleged that out-of-home care was frequently imposed on parents who needed only day care or financial assistance. They argued that the provision of intensive, in-home services could frequently avert placement, at lower cost and with less harm. For those cases in which placement could not be averted, they urged that short-term, intensive services would enable most children to safely return home. There was little evidence to support any of these propositions. Worse, there was evidence that contradicted them.<sup>23</sup> For example, a case survey conducted during the mid-1970s demonstrated that the problems which led to foster placement were rarely confined to day care or financial assistance; instead, they were serious and multiple.<sup>24</sup> During the 1980s and 1990s, evidence continued to accumulate showing that *all* of the assumptions on which the reform program was premised were deeply flawed: case surveys showed that parents whose children went into foster care were overwhelmed with problems,<sup>25</sup> and that intensive, in-home supervision typically did not work; many children were ultimately placed in foster care and – of even greater concern – children left at home with intensive supervision were at risk of continuing abuse or neglect.<sup>26</sup> Reunification services were also found wanting. Children

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<sup>23</sup> See *Child Welfare Decisionmaking*, *supra* note 2, at 1762-1766 (describing deficiencies in evidentiary basis of reform literature).

<sup>24</sup> See BLANCHE BERNSTEIN ET AL., A PRELIMINARY REPORT: FOSTER CARE NEEDS AND ALTERNATIVES TO PLACEMENT 23-24 (1975) (trained case readers found that in only 7.3% of foster care case records examined should the children be returned home. Of this “returnable” group, ninety-eight percent required one or more services in order to make that return possible; forty percent required two or more).

<sup>25</sup> In one often-cited survey, thirty-three percent of the children’s main caretakers suffered from “severe” mental or emotional problems, sixty percent of families included an adult member who used alcohol excessively, twenty percent had at least one member who had been a heroin user, fifty-three percent of main caretakers had a severe physical illness or condition, and seventy-six percent of families had at least one child with a serious health problem. Bernard Horowitz & Isabel Wolock, *Material Deprivation, Child Maltreatment and Agency Interventions Among Poor Families*, in 137 THE SOCIAL CONTEXT OF CHILD ABUSE AND NEGLECT 146 (Leonard Pelton ed., 1981).

<sup>26</sup> See, e.g., MICHAEL S. WALD ET AL., PROTECTING ABUSED AND NEGLECTED CHILDREN 88-89 (1985) (reporting that two-thirds of sample children whose families received intensive in-home services were subject to continuing neglect or abuse); MARY ANN JONES, A SECOND CHANCE FOR FAMILIES— FIVE YEARS LATER: FOLLOW-UP OF A PROGRAM TO REDUCE FOSTER CARE 79-110 (1985); Desmond K. Runyon & Carolyn L. Gould, *Foster Care for Child Maltreatment: Impact on Delinquent Behavior*, in 75 PEDIATRICS 562, 566 (1985) (finding that twenty-five percent of abused children who received in-home services were re-abused). See also NICO TROCME ET AL., MINISTER OF HEALTH, CANADA, CANADIAN INCIDENCE STUDY OF REPORTED CHILD ABUSE AND



were often reunited with their parents only to be returned to foster care;<sup>27</sup> multiple foster care placements had simply been augmented with occasional – equally unstable – home stays.

A third source of failure was reformers' optimistic assessment that major improvements in child welfare outcomes could be obtained at low cost. Because reformers underestimated the gravity of the familial problems that led to placement, it was easy to assume that low-cost, temporary services would keep children out of care and rapidly reunite those who did require temporary placement with their families. Reformers thus did not demand a major financial commitment to research and long-term treatment. Instead, they alleged that reform implementation would rapidly produce public savings.

Taken in historical context, these failures are not surprising. Child protection reform was part of a broader movement that aimed to transform the state's therapeutic institutions. In a variety of contexts, including mental health treatment, juvenile delinquency, the probation and parole systems, reformers urged similar measures designed to minimize state intervention, cabin discretion, and reduce reliance on institutional care. This reform agenda reflected the mood of the moment. Spurred by an unsuccessful war abroad, political scandal at home, and widespread social upheaval, reformers tended to instinctively distrust authority and reflexively seek limitations on its scope.<sup>28</sup> They

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NEGLECT 98 (2001), available at [http://www.phac-aspc.gc.ca/publicat/cisfr-ecirf/pdf/cis\\_e.pdf](http://www.phac-aspc.gc.ca/publicat/cisfr-ecirf/pdf/cis_e.pdf) (showing that in a Canadian survey, fifty-eight percent of physical abuse, sixty-seven percent of neglect, sixty-six percent of emotional maltreatment, and seventy-three percent of multiple-types-of-maltreatment cases had been previously investigated or received services).

<sup>27</sup> See, e.g., TRUDY FESTINGER, RETURNING TO CARE: DISCHARGE AND REENTRY IN FOSTER CARE 1–2 (1994) (surveying reports and noting that as many as 40% of foster children return to care); MARK F. TESTA & ROBERT M. GEORGE, POLICY AND RESOURCE FACTORS IN THE ACHIEVEMENT OF PERMANENCY FOR FOSTER CHILDREN IN ILLINOIS 28, 58–59 (1988) (reporting that in late 1970s, forty percent of sample Illinois foster children who were reunited with family members returned to foster care, and concluding that “the framers of [the Child Welfare and Adoption Assistance Act of 1980] . . . may have been fundamentally mistaken about what the nature of the foster care problem was. Instead of foster-care drift, our analysis suggests it may have been the absence of planning and control in the reunification process”); Elaine Walton et al., *In-Home Family-Focused Reunification: An Experimental Study*, in 72 CHILD WELFARE 473–474 (1993) (reporting that 20% to 40% of foster children reunited with parents will return to care); Wulczyn, *supra* note 7, at 105 (approximately twenty-eight percent of the children admitted in 1990 reentered foster care over the next ten years; after 1997, reentry rates fell, but only because of the shorter observation period).

<sup>28</sup> Even nongovernmental authority was suspect: this is the era in which judges invented the doctrine of informed consent to cabin the discretion of the doctor and

also tended toward optimism about the possibility that long-standing social problems – racial discrimination, poverty, the subjugation of women – could be cured. And distrust for authority did not extend to law, which was typically expected to serve as the primary engine of social change. Given these widespread tendencies, it is not surprising that the reform movement which produced the AACWA would display a strongly anti-authoritarian bent, assume that child welfare workers could easily cure family dysfunction, and vastly underestimate the cost and difficulty of achieving meaningful change.<sup>29</sup>

It is also unsurprising that ASFA and other reforms of the 1990s were much more limited and pessimistic. This was not a time of unbounded optimism or sweeping social change. It was a time in which legislators often embraced private, market mechanisms instead of publicly funded programs. This tendency is evident in government policies toward welfare reform, medical care and education. It is also evident in the ASFA's focus on adoption, where a shortage of healthy white infants has made less "desirable" children – like those who come through the foster care system – potentially adoptable.

I do not mean to suggest that either the earlier reform movement or the later one is responsible for the current crisis in child protection. It is not obvious that anyone could have foreseen the caseload explosion that took place during the late 1980s and early 1990s; indeed, it is unclear, even in retrospect, that we completely understand it. Although most experts attribute the initial case explosion to the crack cocaine epidemic that ravaged many poor urban neighborhoods during the mid 1980s, continuing high caseloads appear to stem from many factors, including other forms of addiction and improved maltreatment reporting.<sup>30</sup>

Nor do I mean to suggest that the reforms sought were inappropriate. Case planning and review are obvious preconditions to successful

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propounded the notion that children had rights to limit the authority of educators. See MARSHA GARRISON & CARL E. SCHNEIDER, *THE LAW OF BIOETHICS: INDIVIDUAL AUTONOMY AND SOCIAL REGULATION* 5-15, 1101-02 (2003) (discussing origins of movement in favor of patient autonomy and informed consent doctrine); HARRY E. KRAUSE ET AL., *FAMILY LAW: CASES, QUESTIONS, COMMENTS* 428-30 (5th ed. 2003) (discussing origins of children's rights movement).

<sup>29</sup> See *Child Welfare Decisionmaking*, *supra* note 2, at 1761 (describing the failure of mental-hospital deinstitutionalization movement).

<sup>30</sup> See NAT'L CENTER ON ADDICTION & SUBSTANCE ABUSE AND CHILD WELFARE, *SUBSTANCE ABUSE AND MENTAL HEALTH ADMINISTRATION, NO SAFE HAVEN: CHILDREN OF SUBSTANCE-ABUSING PARENTS* (1999), available at <http://www.ncsacw.samhsa.gov/files/508/NoSafeHaven.htm>.

treatment. Certainly child protection agencies should keep children at home when possible and, in most cases, provide services calculated to reunite children and parents without delay. Certainly, if parental reunification cannot be effected, agencies should work to find children permanent homes elsewhere.

However, the reforms sought were clearly inadequate: they underestimated the gravity of the problems that child protection workers confront, ignored the lack of proven remedial treatments, and failed to take account of long-term institutional difficulties in training and retaining qualified, expert staff with reasonable caseloads.<sup>31</sup> Successful reforms require sound data on the problem to be addressed, the range of potential remedies, the institutions to which those remedies will be entrusted, and the limitations inherent in these remedies and institutions. Changes in child protection law and practice thus should be grounded in a thorough understanding of the sources, types, and risks associated with familial problems that lead to reports of child maltreatment, the pros, cons, and cost of alternative treatment methodologies, and the methods, structure, and staffing of the child welfare system. Thus far, both legal and practice reforms have failed to meet these criteria.

### III. CHILD PROTECTION LAW AND PRACTICE: A PUBLIC HEALTH PERSPECTIVE

#### *A. Advantages and Methods*

The field of public health offers an alternative approach to child protection reform. Indeed, the U.S. Centers for Disease Control now classifies child maltreatment as a public health problem and has various maltreatment prevention research projects underway.<sup>32</sup> The public health system offers more than a classificatory scheme and additional resources, however. It also offers a distinctive methodology that represents a considerable improvement over that utilized in the reform movements described in Section II.

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<sup>31</sup> See *Child Welfare Decisionmaking*, *supra* note 2, at 1767 (noting that “[o]ver the last twenty years researchers have repeatedly found that child welfare work suffers from high caseloads, rapid staff turnover, and inadequate training”).

<sup>32</sup> See Rodney W. Hammond, *Public Health and Child Maltreatment Prevention: The Role of the Centers for Disease Control and Prevention*, 18 *CHILD MALTREATMENT* 81, 82-83 (2003).

The first advantage of a public health perspective is that we tend to adopt a more neutral, fact-based stance toward disease than we do toward problems defined as social and political. A public health perspective thus discourages reliance on ideology and preconception; it instead encourages the search for knowledge and hard data.<sup>33</sup> The field of public health also offers a robust methodology developed over many decades. In contrast to child protection policymakers, public health officials rely on well-established empirical methods and can show a record of success. Finally, the public health perspective reminds us of the gravity of the stakes. Were there a physical illness that threatened the health and well-being of more than half a million American children, we would deem it a public emergency. Child maltreatment does seriously threaten the health and well-being of at least this many children. It is time to treat this problem as the grave threat that it is.

The field of public health emerged during the nineteenth century as scientists began to uncover environmental vectors – unsanitary drinking water, germs, insects – that promoted disease. Experts in this new field sought an understanding of the causes, distribution, and risk factors associated with disease onset as well as protective factors associated with disease resistance. Based on that understanding, they developed prevention programs targeted at populations instead of treatments aimed at individuals.<sup>34</sup>

The preventive approach pioneered by the public health movement is now an established and important part of government's response to physical illness. Prevention is the norm, particularly when the illness in question poses risks of long-term harm and the available treatment modalities work poorly. The evidence suggests that child maltreatment amply meets both of these criteria. It also suggests that the methods of public health are readily adaptable to the problems posed by this disorder.

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<sup>33</sup> Medical practitioners are of course not immune to reliance on preconception and shoddy data. For example, it took a decade for before well-designed research studies revealed that estrogen replacement therapy provided post-menopausal women with no measurable health advantage. See Leslie Berger, *Two Years After On Hormone Therapy, the Dust Is Still Settling*, N.Y. TIMES, June 6, 2004, §15, at 1.

<sup>34</sup> See generally DIV. OF HEALTH CARE SERVICES., INST. OF MED. COMM. FOR STUDY OF FUTURE OF PUBLIC HEALTH, *THE FUTURE OF PUBLIC HEALTH* (1989); F. Douglas Skutchfeld & William Keck, *Concepts and Definitions of Public Health Practice*, in 2 PRINCIPLES OF PUBLIC HEALTH PRACTICE 3 (2002).

*B. The Need for Prevention: Epidemiology, Treatment, and Diagnosis of Child Maltreatment*

1. Child Maltreatment Produces Serious, Long-Term Harm

While much remains to be learned, researchers have already produced a large amount of epidemiological data on child maltreatment. These data demonstrate that the harm associated with maltreatment is profound and long-lasting. Indeed, in the United States, the federal government estimates that at least fourteen hundred children died in 2002 as a result of child maltreatment;<sup>35</sup> as death certificates tend to under-report maltreatment, the real death toll is probably much higher.<sup>36</sup> More than ninety-five percent of serious intracranial injuries during the first year of life and eighty-five percent during the first two years result from maltreatment.<sup>37</sup> Children who are maltreated are also far more likely than others to suffer from cognitive deficits, personality disorders, and untreated physical health problems. For example, in one survey that analyzed the health of all children entering foster care in a mid-size U.S. city over a two-year period,

[more than] 90% of the children had an abnormality in at least one body system, 25% failed the vision screen, and 15% failed the hearing screen. The children were also lighter and shorter than the norm. Mental health screening revealed that . . . [, o]f children older than 3 years of age, 15% admitted to or were suspect for suicidal ideation and 7% for homicidal ideation. Of the children younger than 5 years of age, 23% had abnormal or suspect results on developmental screening examinations. At the time of entry into foster care, 12% of the children required an antibiotic. More than half needed urgent or nonurgent referrals for medical services and, for children > 3 years of age, more than half needed urgent or nonurgent referrals for dental and

<sup>35</sup> See U.S. ADMIN. FOR CHILDREN & FAMILIES, U.S. DEPT. OF HEALTH & HUMAN SERVICES., *CHILD ABUSE AND NEGLECT FATALITIES: STATISTICS AND INTERVENTION* (2004), available at <http://nccanch.acf.hhs.gov/pubs/factsheets/fatality.cfm>.

<sup>36</sup> See Tessa L. Crume et al., *Underascertainment of Child Maltreatment Fatalities by Death Certificates, 1990-1998*, 110 *PEDIATRICS* 2, 20 (2002).

<sup>37</sup> See Anne D. Libby, *Costs of Childhood Physical Abuse: Comparing Inflicted and Unintentional Traumatic Brain Injuries*, 112 *PEDIATRICS* 58, 58 (2003).

mental health services. Just 12% of the children required only routine follow-up care.<sup>38</sup>

Because the maltreatment that leads to foster-care placement has already produced these serious harms,

[m]any studies of foster children postulate that a majority have mental health difficulties. They have higher rates of depression, poorer social skills, lower adaptive functioning, and more externalizing behavioral problems, such as aggression and impulsivity. Additionally, research has documented high levels of mental health service utilization among foster children due to both greater mental health needs and greater access to services.<sup>39</sup>

The problems induced by maltreatment are expensive. For example, researchers who analyzed Medicaid expenditures in the state of Washington found that mean health care costs for foster children were \$3,075, compared to \$543 for children in the Aid to Families with Dependant Children (AFDC) public assistance program.<sup>40</sup> The same researchers estimated that foster children accounted for somewhere between 25-41% of *total* annual expenditures for Medicaid mental health services.<sup>41</sup> Of course, mental health services represent only the tip of the iceberg: one advocacy organization attempted to tally the total costs of maltreatment and, using the “best available research and conservative estimates,” concluded that direct costs totaled more than

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<sup>38</sup> See Robin A. Chernoff et al., *Assessing the Health Status of Children Entering Foster Care*, 93 PEDIATRICS 594, 594 (1994). See also KATHERINE KORTENKAMP & JENNIFER EHRLE MACOMBER, URBAN INSTITUTE, WELL-BEING OF CHILDREN INVOLVED WITH THE CHILD WELFARE SYSTEM: A NATIONAL OVERVIEW tbl. 3. (Jan. 15, 2002), available at <http://www.urban.org/url.cfm?ID=310413>; Sarah McCue Horwitz et al., *Specialized Assessments for Children in Foster Care*, 106 PEDIATRICS 59, 59 (2000) (estimating that, among children entering foster care, thirty to eighty percent have mental health problems, forty to eighty percent a chronic physical health problem, and more than forty percent a growth abnormality). See generally K.E. Bolger & C.J. Patterson, *Pathways from Child Maltreatment to Internalizing Problems: Perceptions of Control as Mediators and Moderators*, 13 DEV. & PSYCHOPATHOLOGY 913 (2001).

<sup>39</sup> KORTENKAMP & MACOMBER, *supra* note 38, tbl. 3; Brenda Jones Harden, *Safety and Stability for Children in Foster Care: A Developmental Perspective*, in 14 THE FUTURE OF CHILDREN: CHILDREN, FAMILIES, AND FOSTER CARE, at 31. See also Bolger & Patterson, *supra* note 38, at 916-919. See generally J.M. Clausen et al., *Mental Health Problems of Children in Foster Care*, 78 J. CHILD & FAM. STUDIES 221 (1998).

<sup>40</sup> J.I. Takayama et al., *Children in Foster Care in the State of Washington: Health Care Utilization and Expenditures*, 271 JAMA 1850, 1852 (1994).

<sup>41</sup> *Id.* at 1853.

twenty-four billion dollars and indirect costs more than ninety-four billion dollars each year.<sup>42</sup>

These problems and associated costs often persist throughout a child's stay in foster care. Although the evidence suggests that foster care often produces more positive outcomes than family reunification,<sup>43</sup> it also demonstrates that many foster children fail to outgrow the problems they brought with them into placement.<sup>44</sup> Children who remain in foster care until the age of majority, for example, exhibit a wide range of profoundly dysfunctional behaviors. A national study of the Title IV-E foster care independent living program, which is supposed to assist foster children in the transition to self-sufficiency, found that, thirty months to four years after aging out of the system, forty-six percent of those surveyed had not completed high school, thirty-eight percent had not held a job for longer than one year, twenty-five percent had been homeless for at least one night, sixty percent of women had given birth to a child, and forty percent had been on public assistance, incarcerated, or a cost to the community in some other way.<sup>45</sup>

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<sup>42</sup> PREVENT CHILD ABUSE AMERICA, TOTAL ESTIMATED COST OF CHILD ABUSE AND NEGLECT IN THE UNITED STATES: STATISTICAL EVIDENCE (2001), available at [http://www.preventchildabuse.org/learn\\_more/research\\_docs/cost\\_analysis.pdf](http://www.preventchildabuse.org/learn_more/research_docs/cost_analysis.pdf).

<sup>43</sup> See Richard Barth & D. Blackwell, *Death Rates Among California's Foster Care and Former Foster Care Populations*, 20 CHILDREN & YOUTH SERVICES REV. 577, 578 (1998); S.M. Horowitz et al., *Foster Care Placement Improves Children's Functioning*, 155 ARCH. PEDIATR. ADOLESC. MED. 1255, 1258 (2001); Heather N. Taussig et al., *Children Who Return Home from Foster Care: A 6-Year Prospective Study of Behavioral Health Outcomes in Adolescence*, 108 PEDIATRICS 62, 62 (2001).

<sup>44</sup> P. Cohen et al., *Child Abuse and Neglect and the Development of Mental Disorders in the General Population*, 13 DEV. & PSYCHOPATHOLOGY 981, 993 (2001). See generally R.C. Herrenkohl et al., *Preschool Antecedents of Adolescent Assaultive Behavior: A Longitudinal Study*, 67 AM. J. ORTHOPSYCHIATRY 422 (1997). Cathy Spats Widom, *A Prospective Examination of Risk for Violence among Abused and Neglected Children*, 794 ANNALS N.Y. ACAD. SCIENCES 224, 232-233 (1996).

<sup>45</sup> U.S. GEN. ACCT. OFF., FOSTER CARE: EFFECTIVENESS OF INDEPENDENT LIVING SERVICES UNKNOWN 3-4 (1999) (citing National Evaluation of Title IV-E Foster Care Independent Living Program for Youth: Phase II Final Report, Vols. I and II (Westat, Inc., 1991)). In another state study, twenty-seven percent of males and ten percent of females were incarcerated within eighteen months, fifty percent were unemployed, thirty-seven percent had not finished high school, thirty-three percent received public assistance, and nineteen percent of females had given birth to children. Before leaving care, forty-seven percent were receiving counseling or medication for mental health problems. M.E. Courtney et al., *Foster Youth Transitions to Adulthood: A Longitudinal View of Youth Leaving Care*, 80 CHILD WELFARE 685, 706-13 (2001). See Ruth Massinga & Peter J. Pecora, *Providing Better Opportunities for Older Children in the Child Welfare System*, in 14 THE FUTURE OF CHILDREN: CHILDREN, FAMILIES, AND FOSTER CARE at 151, 153-54 (summarizing studies).

The harms associated with child maltreatment appear to be universal. In the U.K., a government survey found that more than half of children in the care of Welsh child protection authorities had a conduct or emotional disorder: forty-two percent had clinically significant conduct disorders, twenty percent had emotional disorders such as anxiety and depression, and twelve percent were hyperactive.<sup>46</sup> Moreover, two-thirds had at least one physical complaint, and more than sixty-eight percent were at least one year behind in their intellectual development.<sup>47</sup>

The adverse effects of childhood maltreatment may also persist into adult life. For example, in a survey of addicts in drug treatment, two-thirds reported that they had been physically or sexually abused as children.<sup>48</sup> Another survey found that formerly abused and neglected children were more than three times as likely to be arrested for a violent crime as compared with a matched control group.<sup>49</sup> And a Canadian study revealed that more than a third of surveyed child protection cases

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<sup>46</sup> HOWARD MELZER ET AL., OFF. NAT'L STAT.: WELSH ASSEMBLY GOV'T, MENTAL HEALTH OF YOUNG PEOPLE LOOKED AFTER BY LOCAL AUTHORITIES IN WALES (2004), available at <http://www.statistics.gov.uk/statbase/Product.asp?vlnk=12547&More=n>. Similar results were reached in a Scottish survey. BBC News, *Study Reveals Child Care Problems* (May 27, 2004), available at [http://news.bbc.co.uk/2/hi/uk\\_news/scotland/3755437.stm](http://news.bbc.co.uk/2/hi/uk_news/scotland/3755437.stm).

<sup>47</sup> MELZER, *supra* note 46, at xii, 37.

<sup>48</sup> NAT'L CONF. ST. LEGISLATURES, LINKING CHILD WELFARE AND SUBSTANCE ABUSE TREATMENT: A GUIDE FOR LEGISLATORS xii, 37 (Aug. 2000), available at <http://www.ncsl.org/programs/pubs/xsmabuse.htm>. See also David Bernstein et al., *Predicting Personality Pathology Among Adult Patients with Substance Use Disorders: Effects of Childhood Maltreatment*, 23 ADDICTIVE BEHAVIORS 855, 863-66 (1998) (reporting significant relationship between type of childhood maltreatment and personality disorder clusters in a group of substance abusers: physical abuse and physical neglect were related to a subcluster of "psychopathic" personality disorders, consisting of childhood and adult antisocial personality traits and sadistic traits; emotional abuse emerged as a broad risk factor for some types of personality disorders); Valerie J. Edwards & George W. Holden, *Relationship Between Multiple Forms of Childhood Maltreatment and Adult Mental Health in Community Respondents: Results From the Adverse Childhood Experiences Study*, 160 AM. J. PSYCHIATRY 1453, 1457-59 (2003) (reporting that lower mean mental health scores were associated with higher numbers of abuse categories reported).

<sup>49</sup> Diana J. English et al, *Childhood Victimization and Delinquency, Adult Criminality, and Violent Criminal Behavior: A Replication and Extension*, 251 NIJ J. 23, 23 (2004), available at <http://ncjrs.org/pdffiles1/jr000251g.pdf>. See also Cathy Spats Widom et al., *Child Abuse and Later Effects*, 242 NIJ J. 2, 7 (2000), available at <http://ncjrs.org/pdffiles1/jr000242b.pdf>. See generally Shanta R. Dube et al., *Childhood Abuse, Household Dysfunction, and the Risk of Attempted Suicide throughout the Life Span: Findings from the Adverse Childhood Experiences Study*, 286 JAMA 3089 (2001).



involved a parent who had been the child client of a protection agency.<sup>50</sup> The national Adverse Childhood Experiences (ACE) research project has also documented a link between childhood trauma such as maltreatment and alcoholism, depression, suicide attempt, smoking, poor self-rated health, multiple sexual partners and sexually transmitted disease, and even adult physical ills such as ischemic heart disease, cancer, chronic lung disease, skeletal fractures, and liver disease.<sup>51</sup> While the pathway between childhood maltreatment and this startlingly large array of adverse adult consequences is still unclear, researchers who measured physical reactions to stress in a group of adult women found that those who had been maltreated during childhood exhibited responses that were significantly elevated as compared to a control group. Indeed, women with both a history of childhood abuse and a current diagnosis of major depression exhibited a stress response more than six times greater than that of age-matched controls.<sup>52</sup> Adults maltreated during childhood thus contend not only with a lack of positive adult role models, but also with heightened sensitivity to stress that may strongly predispose them to the later-life psychological and physical ills.<sup>53</sup>

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<sup>50</sup> See DERMOT J. HURLEY ET AL., INTERGENERATIONAL CONTINUITY AND LIFE COURSE TRAJECTORY IN A CHILD PROTECTION SAMPLE: IMPLICATIONS FOR SOCIAL WORK PRACTICE 7 (Oct. 2003), available at <http://www.edu.uwo.ca/CAS/pdf/Intergenerational%20Continuity%20september182003.pdf>. See also T.F. Locke & M.D. Newcomb, *Intergenerational Cycle of Maltreatment: A Popular Concept Obscured by Methodological Limitations*, 25 CHILD ABUSE & NEGLECT: INT'L JOURNAL 1219, 1219 (2001); K.C. Pears & D.M. Capaldi, *Intergenerational Transmission of Abuse: A Two Generational Prospective Study of an At-Risk Sample*, 25 CHILD ABUSE & NEGLECT 1439 (2001); Peter Sidebotham et al., *Child Maltreatment in the "Children of the Nineties": A Longitudinal Study of Parental Risk Factors*, 25 CHILD ABUSE & NEGLECT 1177, 1177 (2001) (asserting that history of childhood sexual abuse, but not other forms of maltreatment, was a significant predictor of maltreatment of one's children).

<sup>51</sup> Vincent J. Felitti et al., *Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults: The Adverse Childhood Experiences (ACE) Study*, 14 AM. J. PREVENTIVE MED. 245, 251-256 (1998). See also S.J. Dallam, *The Long-Term Medical Consequences of Childhood Trauma*, in 1 THE COST OF CHILD MALTREATMENT: WHO PAYS? WE ALL DO 1-8 (Kris Franey et al. eds., 2001); R.A. Colman & C.S. Widom, *Childhood Abuse and Neglect and Adult Intimate Relationships: A Prospective Study*, 28 CHILD ABUSE & NEGLECT 1133, 1146-1148 (2004) (showing that childhood victims of substantiated abuse and neglect had significantly higher levels of divorce, cohabitation, and walking out than matched controls when interviewed as adults).

<sup>52</sup> See Christine Heim et al., *Pituitary-Adrenal and Autonomic Responses to Stress in Women after Sexual and Physical Abuse in Childhood*, 284 JAMA 592, 592 (2000).

<sup>53</sup> *Id.* at 596.

In sum, the evidence shows that child maltreatment is associated with serious mental and physical health problems during childhood. It also shows that childhood problems often persist and contribute to a wide range of social, emotional, and physical maladies that can significantly impair adult functioning.

## 2. Child Maltreatment Lacks Proven, Evidence-Based Treatments

Child maltreatment is a “two-person” disorder: a parent behaves inappropriately, and his or her child suffers physical, emotional or cognitive harm. Treatment needs are thus multiplied: the affected child requires treatment to avoid long-term adverse consequences; the parent requires treatment to substitute appropriate child-care patterns for maltreatment.

In assessing treatments for both the harms caused by child maltreatment and the behaviors that constitute it, we are hampered by inadequacies in the treatment literature. The literature is sparse. More importantly, it rarely takes account of either individual characteristics or maltreatment type; it typically relies on small samples and fails to utilize appropriate control groups. For example, Professor Duncan Lindsey, who conducted an exhaustive survey of the literature on family preservation services, was able to identify twenty-five relevant studies, but only four met the requirements of conventional experimental design, i.e., minimum sample size, treatment and control groups, random assignment of subjects and a post-sample comparison of what changes may have occurred among the two groups due to application of the experimental variable.<sup>54</sup>

Research that conforms to standard experimental protocols is crucial if we are to learn what works. In Professor Lindsey’s family preservation research review, the control group actually fared better than the experimental group receiving the family preservation services in two of the four well-designed studies; in the other two well-designed studies, the services group showed a slightly, but not significantly, improved result.<sup>55</sup> And when placement prevention was the outcome variable, *none* of the four well-designed clinical trials found a statistically significant difference in favor of family preservation.<sup>56</sup> “Only when the research study was so weakly designed as to be merely descriptive in

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<sup>54</sup> See DUNCAN LINDSEY, PRESERVING FAMILIES AND PROTECTING CHILDREN: FINDING THE BALANCE (1996), available at <http://www.childwelfare.com/kids/fampres.htm>.

<sup>55</sup> *Id.*

<sup>56</sup> *Id.*

nature did the results appear to support the family preservation program.”<sup>57</sup>

It is also crucial that well-designed research take place before major funding initiatives are launched. Despite the fact that well-designed research shows no benefits from family preservation, at the time Professor Lindsey completed his evaluation, the federal government had already spent more than a billion dollars on establishing state family preservation programs.<sup>58</sup>

Of course, the child protection field is far from unique in its reliance on unproven treatment strategies. Researchers recently reported that DARE, the most widely used school-based substance abuse prevention program in the United States, simply does not work.<sup>59</sup> Even in the field of medicine, doctors prescribed estrogen supplements for millions of women over many years before research established that the treatments were worthless.<sup>60</sup> But in the field of child welfare, untested treatments appear to be the rule rather than the exception.

Because well-designed research studies have been so rare, we simply do not have evidence-based treatments for neglect and abuse that deserve a major investment of public funds. We know literally nothing about the extent to which the childhood disorders associated with maltreatment improve during foster care or the individual characteristics, services, and care settings that are associated with improvement. We know next to nothing about either the specific problems – cognitive, educational, emotional – that maltreated children exhibit or the success rates of different treatment modalities. Despite the rapid growth of “kinship” foster care, we know next to nothing about when kinship care is desirable and when it is not.<sup>61</sup>

<sup>57</sup> UCLA School of Public Policy & Soc. Research, *Child Cares*, CHALLENGE (Spr. 1997), available at <http://www.research.ucla.edu/chal/31.htm>. (quoting Professor Duncan Lindsey) (on file with author).

<sup>58</sup> See LINDSEY, *supra* note 54, at *Conclusion*.

<sup>59</sup> See Brian Vastag, *DARE Does Not Work*, 289 JAMA 539, 539 (2003) (finding that program neither prevents drug use nor change students’ attitudes toward drugs).

<sup>60</sup> See Berger, *supra* note 33.

<sup>61</sup> See JOAN HUNT, FAMILY AND FRIENDS CARERS REPORT: SCOPING PAPER PREPARED FOR THE DEPARTMENT OF HEALTH 12-42 (2003), available at <http://www.doh.gov.uk/carers/familyandfriends.htm> (surveying research reports and concluding (at 39) that the “evidence for the actual and potential benefits and risks of kinship foster care is inconclusive and complex”). See also U.S. DEP’T OF HEALTH & HUMAN SERVICES, REPORT TO CONGRESS ON KINSHIP FOSTER CARE vi (2000) (reporting that children in kinship care are less likely to be reunified with their birth parents and to receive

Data are equally sparse with respect to the treatment of behaviors that constitute child maltreatment. We do know that reunification is less likely if either the child in placement or her parents are afflicted with many problems,<sup>62</sup> but beyond these unsurprising basics, we know extraordinarily little. There is no literature comparing the value of different interventions in controlled, randomly selected populations. There is no literature relating treatment options to specific forms of parental dysfunction. There is no literature describing the parental and program characteristics that predict treatment success and, beyond the obvious finding that many problems are harder to treat than few problems, the characteristics that predict failure.

### 3. Child Protection Lacks Standardized Diagnostic Procedures and Data on Institutional Context

The treatment literature exhibits these gaping holes, at least in part, because child protection personnel typically fail to diagnose specific treatment needs; indeed, they often fail to utilize diagnostic procedures altogether. During the symposium panel discussion, the experts quickly labeled Jamel, age fourteen, as “parentalized” and “truant.” His mother was “addicted,” his grandmother “overwhelmed.” But none of the experts noted that the child protection agency had failed to conduct physical, mental, developmental, or educational assessments of the parties; none indicated that he or she would request such assessments; none attempted to formulate a case plan that would take account of specific functional deficits and treat those deficits.

Assessment of children’s developmental and health status would seem to be crucial to a determination of whether the risks inherent in the agency’s actions were worth the potential gain. These risks are not insignificant. Aside from the obvious risks posed by separating children from their parents and often from each other, national surveys suggest that many foster children are placed with caregivers who exhibit symptoms of poor mental health and high levels of aggravation, or who provide little stimulation for young children.<sup>63</sup> Such assessments would

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supportive services, including mental health and substance abuse services, during placement).

<sup>62</sup> See Wulczin, *supra* note 7, at 99 (citing studies and also noting parental ambivalence as a factor in reunification).

<sup>63</sup> See KORTENKAMP & MACOMBER, *supra* note 38, at *Caregiver Well-Being and Interactions* (reporting, based on national survey, that seventeen percent of children involved with child welfare were living with a caregiver who exhibited symptoms of poor mental health, twenty-six percent were living with a “highly aggravated” caregiver,

seem to be equally crucial to the formulation of a treatment plan, progress reports, and reunification assessments. Of course, they are also crucial to a determination of whether agency intervention produces improvement in the children's baseline condition.

The patterns exhibited in the panel discussion are, unfortunately, common. Agency investigation tends to focus narrowly on the specific incident reported to the authorities. All too often, it involves nothing more than a "ritual performance . . . focused on the misdemeanour committed by the mother in leaving her children unattended, measured against the appropriateness of her reaction to the social worker."<sup>64</sup> Decision making tends to be black and white: either the case is closed, or the child is placed in foster care.

Of course, front-line caseworkers should not be expected to conduct detailed medical assessments; they are the equivalent of EMTs, whose job is to assess the need for immediate care and provide transport to the hospital. But child protection assessment often fails to advance beyond the emergency stage, without diagnostic follow-up, specialist referrals, and a coordinated treatment plan.<sup>65</sup>

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and that, of children under age six, twenty-six percent lived with a caregiver who read to them two or fewer times a week and twenty-four percent with a caregiver who took them on outings (e.g., park, grocery store, church, playground) two to three times a month or less). The authors concluded that, although fewer foster children than children living with high-risk parents have a caregiver with poor mental health, "more children placed in foster or relative care are living with a highly aggravated caregiver than are children in high-risk parent care."

<sup>64</sup> Helen Buckley, *Child Protection Practice: An Ungovernable Enterprise?*, 1 *ECON. & SOC. REV.* 21, 31-32 (1999) (reporting that, "[o]f the nine allegations of neglect investigated with a parental interview. . . , all the families concerned were experiencing a variety of other problems, including marital disharmony, housing difficulties, problems associated with lone parenthood, addiction, chronic illness, and depression. The investigative interviews, however, concentrated on the specific incident which led to the concern. In five out of the nine investigations, social workers recommended no further action, even though in three of them, "neglect" was established, and in the other two, it was not disproved. The four cases where further interventions were recommended, and were allocated, included the three where the mothers' drinking caused significant and visible difficulties, and one which had a protracted history of poor quality care and supervision") See also *SHORTENING CHILDREN'S STAYS*, *supra* note 19, at 9 ("Even when treatment resources do exist, few systems assess the risks to a child early in a case and tailor the case plan accordingly. Many workers prescribe the same level of services for all families, failing to distinguish those families who are likely to be preserved from those who are not.").

<sup>65</sup> In reviews conducted by the federal government, no state child protection system achieved "substantial compliance" with the goal of ensuring that "families have enhanced capacity to provide for children's needs"; thirty percent substantially complied

Lack of standardized diagnostic assessments – or any assessment at all – contributes to current ignorance of appropriate and effective treatments. It also impedes meaningful comparisons between child protection agencies. In the medical context, researchers have tracked significant variation in treatment patterns and success rates both by regions and institutions. These data have been valuable in the development of standardized, evidence-based treatments that are maximally effective and cost-efficient; they have also been important in weeding out substandard treatment programs and protocols.<sup>66</sup> However, in the field of child protection, we have virtually no data on variation in diagnostic and treatment methodologies or success rates. It is possible that there are child protection agencies using effective methods that other agencies could adopt, but we have no ability to identify them.

We also lack information about successful personnel characteristics. The child protection literature routinely decries the lack of experienced personnel.<sup>67</sup> But for what type of tasks is a well-trained, experienced social worker necessary? Are there tasks that low-level personnel can perform ably? What case loads are ideal and what are impossible? Should case workers specialize as doctors do? Is an investigative and therapeutic role combined in one worker counterproductive, as some experts have alleged?<sup>68</sup> These are all important questions in developing efficient treatment methods that make maximal use of scarce personnel, but we simply do not know the answers. As a result, the child protection bureaucracy tends to use highly trained personnel indiscriminately – as if the neurosurgeon were also giving vaccinations – without regard to cost or need.

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with the goal of ensuring that “[c]hildren receive services to meet their educational needs,” and one substantially complied with the goal of ensuring that “[c]hildren receive services to meet their physical and mental health needs.” U.S. ADMIN. FOR CHILDREN & FAMILIES, U.S. DEPT. OF HEALTH & HUMAN SERVICES, GENERAL FINDINGS FROM THE FEDERAL CHILD AND FAMILY SERVICES REVIEW tbl. 1-1 (2004), available at <http://www.acf.hhs.gov/programs/cb/cwrp/results/statefindings/genfindings04/ch1.htm>.

<sup>66</sup> See, e.g., J.E. WENNBURG & M.M. COOPER, THE DARTMOUTH ATLAS OF HEALTH CARE IN THE UNITED STATES (1996), available at <http://www.dartmouthatlas.org>. See generally M.R. Chassin et al., *Variations in the Use of Medical and Surgical Services by the Medicare Population*, 314 NEW ENG. J. MED 285 (1986). Gerald T. O’Connor et al., *Geographic Variation in the Treatment of Acute Myocardial Infarction: The Cooperative Cardiovascular Project*, 328 JAMA 627, 627 (1999).

<sup>67</sup> See sources cited *supra* notes 20-22.

<sup>68</sup> See, e.g., Leroy H. Pelton, *Four Commentaries: How We Can Better Protect Children from Abuse and Neglect*, 8 THE FUTURE OF CHILDREN: PROTECTING CHILDREN FROM ABUSE AND NEGLECT 126, 127 (Spring 1998).

In sum, we are at an extremely early point in the development of evidence-based treatment for child abuse and neglect. Data are accumulating, but much more research is needed. Indeed, before we can design an effective child protection system, much more research is crucial.

### *C. An Ounce of Prevention Is Worth a Pound of Cure*

While the child protection system clearly needs to invest resources in developing standardized diagnostic screening protocols and effective, evidence-based treatments, the fact that these tools are currently unavailable strongly suggests the need for preventive strategies like those developed by the public health movement: if we typically fail to cure, it is even more critical that we prevent.

Three additional factors make preventive strategies seem imperative. First, current treatment options for child maltreatment are expensive as well as unproven. The cost of a year's placement in foster care may be as high as fifty thousand dollars. Even intensive in-home services cost as much as six or seven thousand dollars per family annually.<sup>69</sup> Second, current treatment options themselves involve risks. The longer a child remains in foster care, the greater the likelihood of multiple placements and weakened ties with her biological family, both of which have been linked to worse outcomes for children and higher public costs.<sup>70</sup> The provision of in-home services also poses risks, as this approach has been linked with continuing maltreatment and resulting harm.<sup>71</sup> Third, the adoption "treatment" currently emphasized by ASFA is a scarce resource and cannot possibly be expanded to benefit all maltreated children. Given the imbalance between the supply of adoptive homes and demand by foster children who need them,<sup>72</sup> it also seems certain that those who have been most damaged by child maltreatment will be least likely to benefit from this treatment form. It also seems certain that badly damaged children who are adopted will be at particularly high risk

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<sup>69</sup> N.Y.C. PUBLIC ADVOCATE, CUTS COST: A HISTORICAL AND TREND ANALYSIS OF THE EFFECTS OF PROPOSED PREVENTIVE SERVICE BUDGET CUTS ON THE INCREASE IN FOSTER CARE PLACEMENTS (May 19, 2003), available at [http://www.pubadvocate.nyc.gov/reports/final\\_analysis\\_5-19-03.shtml](http://www.pubadvocate.nyc.gov/reports/final_analysis_5-19-03.shtml) (providing estimates for New York City using federal data).

<sup>70</sup> See, e.g., David H. Rubin et al., *Placement Stability and Mental Health Costs for Children in Foster Care*, 113 PEDIATRICS 1336, 1339 (2004) (finding that both multiple placements and episodic foster care increased the predicted probability of high mental health service use).

<sup>71</sup> See sources cited *supra* note 26.

<sup>72</sup> See sources cited *supra* note 19.

of failed adoption, with all the uncertainty and additional risk that such a result poses. Indeed, we lack convincing evidence that even a successful adoption can cure the various harms associated with serious maltreatment.

## 1. Assessing Prevention as a Child Protection Strategy: Possibilities and Limitations

### *a. Child Maltreatment Risk*

Effective prevention requires an understanding of risks associated with disease onset; unless we know that lung cancer and emphysema are strongly associated with cigarette smoking, we will not be able to envision an anti-smoking campaign. However, we do not need to understand the causation mechanisms that tie smoking to lung cancer or the reasons why some smokers succumb to the disease in order to mount an effective prevention effort; a campaign that targets all smokers will likely be almost as effective as one which targets only those smokers at particularly high risk.

I offer the example of smoking and lung cancer because our knowledge of maltreatment causation and risk is fairly comparable, suggesting that maltreatment prevention is just as viable as smoking prevention. As with lung cancer, we still lack an understanding of the mechanisms that lead to child maltreatment and protective factors that lead most parents to resist the disorder, but environmental conditions that promote child maltreatment have been charted in detail.

Perhaps the most important environmental risk factor is poverty. All forms of child maltreatment are strongly associated with poverty, and neglect – the most common form of maltreatment<sup>73</sup> – is linked with poverty to a startling extent. A national incidence study of maltreatment in the United States found that children from families with annual incomes below fifteen thousand dollars were *sixty times* more likely to die from maltreatment and *twenty-two times* more likely to be seriously harmed than were children from families with annual incomes above thirty thousand dollars.<sup>74</sup> Extreme poverty also tends to be associated

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<sup>73</sup> Again, this appears to be universal. See TROCME ET AL., *supra* note 26, at 15 (reporting that neglect is the most common form of child maltreatment in Canada).

<sup>74</sup> See A.J. SEDLAK & D.D. BROADHURST, U.S. DEPT. OF HEALTH & HUMAN SERVICES, EXECUTIVE SUMMARY OF THE THIRD NATIONAL INCIDENCE STUDY OF CHILD ABUSE AND NEGLECT (NIS-3) (1996) (also reporting that children in these low-income families were eighteen times more likely to be sexually abused, almost fifty-six times



with more extreme abuse and neglect.<sup>75</sup> As a result of these patterns, foster children are overwhelmingly from our poorest families.<sup>76</sup> The association between maltreatment and poverty also seems to be universal,<sup>77</sup> a reminder that the earliest forms of child protection were nothing more than public assistance schemes.<sup>78</sup>

Unsurprisingly, substance abuse,<sup>79</sup> mental health problems,<sup>80</sup> and adult family violence<sup>81</sup> are also highly correlated with child

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more likely to be educationally neglected, and over twenty-two times more likely to be seriously injured).

<sup>75</sup> See COMMISSION ON BEHAVIORAL & SOC. SCIENCES & EDUC., *LOSING GENERATIONS: ADOLESCENTS IN HIGH-RISK SETTINGS* 19 (1993) (summarizing studies).

<sup>76</sup> See BARBELL & FREUNDLICH, *supra* note 11, at 19 (in 1999, more than one-half of U.S. foster children were eligible for federal funding – funding derived from eligibility rules for the defunct Aid to Families with Dependent Children (AFDC) program without adjustments for inflation); NATIONAL RESEARCH COUNCIL, *UNDERSTANDING CHILD ABUSE AND NEGLECT* 9 (National Academy Press, 1993); English et al., *supra* note 49, at 47 (noting that family income is the strongest correlate of maltreatment across categories and that it is especially related to serious neglect and severe violence); Hurley et al., *supra* note 50, at 15 tbl. 4 (reporting significant association between receipt of social assistance and unemployment on child maltreatment).

<sup>77</sup> See NICO TROCME & CLAIRE CHAMBERLAIN, *RE-INVOLVING THE COMMUNITY: THE NEED FOR A DIFFERENTIAL RESPONSE TO RISING CHILD WELFARE CASELOADS IN CANADA* 6 (University of Toronto, 2003), available at [http://www.utoronto.ca/facsocwk/casr/doc/trocme\\_reinvolving.pdf](http://www.utoronto.ca/facsocwk/casr/doc/trocme_reinvolving.pdf) (showing that forty-four of Ontario child neglect cases involved families dependent on social assistance).

<sup>78</sup> See Marsha Garrison, *Why Terminate Parental Rights?*, 35 STAN. L. REV. 423, 424 (1983); Jacobus ten Broek, *California's Dual System of Family Law: Its Origin, Development, and Present Status: Part 1*, 16 STAN. L. REV. 257, 277-299 (1955).

<sup>79</sup> The statistics vary, but studies have generally shown that between one-third and two-thirds of child maltreatment cases involve substance abuse. See GOLDMAN ET AL., OFF. OF CHILD ABUSE & NEGLECT, U.S. DEPT. OF HEALTH & HUMAN SERVICES, *A COORDINATED RESPONSE TO CHILD ABUSE AND NEGLECT: THE FOUNDATION FOR PRACTICE* ch. 5 (2003), available at <http://nccanch.acf.hhs.gov/pubs/usermanuals/foundation/chapfive.cfm#backfiftyone>; U.S. DEPT. OF HEALTH & HUMAN SERVICES, *BLENDING PERSPECTIVES AND BUILDING COMMON GROUND: A REPORT TO CONGRESS ON SUBSTANCE ABUSE AND CHILD PROTECTION* 41 (1999) [hereinafter *BLENDING PERSPECTIVES*]. See also U.S. GEN. ACCT. OFF., *FOSTER CARE: AGENCIES FACE CHALLENGES SECURING STABLE HOMES FOR CHILDREN OF SUBSTANCE ABUSERS* (1998), <http://www.ncsacw.samhsa.gov/files/508/GAOFosterCare.htm> [hereinafter *AGENCIES FACE CHALLENGES*] (showing that sixty-five percent of foster children in California and seventy-four percent of foster children in Illinois had at least one parent who was a substance abuser); Chernoff et al., *supra* note 38, at 592 (showing that seventy-five percent of surveyed children entering foster care had a family history of substance or alcohol abuse). In a recent survey by the National Center on Child Abuse Prevention Research, eighty-five percent of states reported that substance abuse was one of the two major problems exhibited by families in which maltreatment was suspected; NAT'L CENTER ON CHILD ABUSE PREVENTION RESEARCH, *CURRENT TRENDS IN CHILD ABUSE PREVENTION, REPORTING, AND FATALITIES: THE 1999 FIFTY STATE SURVEY* 14 (2001),

maltreatment. So are single parenting,<sup>82</sup> adolescent parenting,<sup>83</sup> lack of social support,<sup>84</sup> and living in a poor neighborhood with a high rate of single parenthood.<sup>85</sup>

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available at [http://www.preventchildabuse.org/learn\\_more/research\\_docs/1999\\_50\\_survey.pdf](http://www.preventchildabuse.org/learn_more/research_docs/1999_50_survey.pdf).

<sup>80</sup> From twenty to seventy percent of maltreating parents have mental health problems. See KATHLEEN COULBORN FALLER & CHRYELL D. BELLAMY, MENTAL HEALTH PROBLEMS AND CHILD MALTREATMENT 1, available at <http://www.ssw.umich.edu/icwtp/mentalHealth/d-mhpar.pdf>.

<sup>81</sup> See Jeffrey L. Edleson, *The Overlap between Child Maltreatment and Woman Battering*, 5 VIOLENCE AGAINST WOMEN 134 (1999) (reviewing thirty-five studies, conducted over a twenty-five year period, that had found an overlap between child maltreatment and domestic violence and concluding that, in thirty to sixty percent of families where either child maltreatment or domestic violence was identified, the other form of violence was also identified). See also VIOLENCE IN FAMILIES: ASSESSING PREVENTION AND TREATMENT PROGRAMS 12 (Rosemary Chalk & Patricia A. King eds., 1998) [hereinafter VIOLENCE IN FAMILIES]; A.E. Appel et al, *The Co-occurrence of Spouse and Physical Child Abuse: A Review and Appraisal*, 12 J. FAM. PSYCHOL. 578, 578 (1998); IN HARM'S WAY: DOMESTIC VIOLENCE AND CHILD MALTREATMENT, available at <http://library.adoption.com/print.php?articleid=3519>.

<sup>82</sup> See SEDLAK & BROADHURST, *supra* note 74 (reporting that children living with single parents had an eighty-seven percent greater risk of being harmed by physical neglect and an eighty percent greater risk of suffering serious injury or harm from abuse and neglect than children living with two parents). See also GOLDMAN ET AL., *supra* note 79. Canadian studies show a similar pattern. See TROCME ET AL., *supra* note 26, at xxv fig. S12 (reporting that forty-six percent of Canadian child maltreatment investigations involved single-parent families, eighteen percent involved "blended families," and twenty-nine percent involved families containing both biological parents). In the U.S., the proportion of foster children who come from single-parent homes appears to be particularly high for African-American children; one small California study found that nearly eighty percent of the African-American foster children in their sample came from single-parent households. See M.S. Harris & M.E. Courtney, *The Interaction of Race, Ethnicity, and Family Structure With Respect to the Timing of Family Reunification*, 25 CHILD. & YOUTH SERVICES REV. 409, 426 (2003). Much of the risk associated with single parenthood derives from maltreatment by a parent's cohabitant. See Michael N. Stiffman et al., *Household Composition and Risk of Fatal Child Maltreatment*, 109 PEDIATRICS 615, 617 (2002) (reporting that children residing in households with adults unrelated to them were eight times more likely to die of maltreatment than children in households with two biological parents and that risk of maltreatment death was not increased for children living with only one biological parent).

<sup>83</sup> See, e.g., Sidebotham et al., *supra* note 50, at 1184 (highlighting that a mother's age of less than twenty was a significant risk factor for child abuse and neglect).

<sup>84</sup> In one often-cited survey, thirty-three percent of the children's main caretakers suffered from "severe" mental or emotional problems, sixty percent of families included an adult member who used alcohol excessively, twenty percent had at least one member who had been a heroin user, fifty-three percent of main caretakers had a severe physical illness or condition, and seventy-six percent of families had at least one child with a serious health problem. See Bernard Horowitz & Isabel Wolock, *Material Deprivation, Child Maltreatment and Agency Interventions Among Poor Families*, in 137 THE SOCIAL CONTEXT OF CHILD ABUSE AND NEGLECT 144-146 (Leonard Pelton ed. 1981). See also

Significantly, these various risk factors are highly correlated with each other: More than eighty percent of teen parents are poor.<sup>86</sup> In up to eighty percent of all incidents of domestic violence, the victim, the batterer, or both, had been drinking.<sup>87</sup> More than a third of women with problem drug use report having experienced a major depressive episode in the past year;<sup>88</sup> eighty-eight percent of women in one drug treatment program reported having experienced severe partner violence at some point, while twenty-six had experienced such violence in the past six months.<sup>89</sup>

Child maltreatment risks also tend to be geographically concentrated. Thus a judge in British Columbia charted, between western and eastern Vancouver, a six-fold difference in income to basic needs, a five-fold difference in the proportion of children under twelve living with a single parent, a ten-fold difference in adult education levels

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TROCME ET AL., *supra* note 26, at xxvii fig. S-14 (showing that, among Canadian child maltreatment investigations, thirty-four percent of caregivers had an alcohol or drug abuse problem, thirty-one percent had a history of childhood abuse, twenty-nine percent lacked social supports, twenty-four percent had a mental health problem, and twenty-three percent involved spousal violence).

<sup>85</sup> See, e.g., C.J. Coulton et al., *Neighborhoods and Child Maltreatment: A Multilevel Study*, 23 CHILD ABUSE & NEGLECT 1019, 1020 (1999); J.L. Spearly & M. Lauderdale, *Community Characteristics and Ethnicity in the Prediction of Child Maltreatment Rates*, 7 CHILD ABUSE & NEGLECT 91, 94 (1983) (the greater the proportions of single mothers and working mothers in a community, the greater its rate of maltreatment; the greater the proportion of families with annual incomes over fifteen thousand dollars, the lower the county maltreatment rate).

<sup>86</sup> THE PARENTING PROJECT, THE NEED TO PREPARE TEENS FOR PARENTING, available at <http://www.parentingproject.org/need.htm#D>.

<sup>87</sup> See Robert Mackey, Facts on Alcohol, Drugs, and Domestic Violence (Rutgers Univ. Center of Alcohol Studies, 1996), available at <http://www.rci.rutgers.edu/~cas2/fact9.shtml>.

<sup>88</sup> SUBSTANCE ABUSE & MENTAL HEALTH SERVICES ADMIN., U.S. DEPT. HEALTH & HUMAN SERVICES, SUBSTANCE ABUSE AMONG WOMEN IN THE UNITED STATES (1997) (stating that forty-five percent reported having experienced at least one of several mental health problems, including panic attacks and anxiety disorders, at some point) (on file with author). See also Wendy Chavkin et al., *Reframing the Debate: Toward Effective Treatment for Inner City Drug-Abusing Mothers*, 70 BULLETIN OF N.Y. ACAD. MED. 50, 50 (1993) (most crack-cocaine using women reported psychiatric symptoms, nearly a third had histories of psychiatric medication or hospitalization, and half reported having been sexually abused as children).

<sup>89</sup> See BLENDING PERSPECTIVES, *supra* note 79, at 59 (citing B. Miller, *Partner Violence Experiences and Women's Drug Use: Exploring the Connection*, in DRUG ADDICTION RESEARCH AND THE HEALTH OF WOMEN (Nat. Inst on Drug Abuse, 1998) & reporting additional research finding that women in substance abuse treatment had much higher rates of partner violence than women in comparative community samples—often two, three, or four times higher depending on the specific type of violence).

and access to child care, and a nine-fold difference in crime.<sup>90</sup> These differences translated into a western Vancouver neglect rate fully *eighty-three times* higher than that of eastern Vancouver.<sup>91</sup>

High rates of child maltreatment are also associated with other risks to child well-being. For example, between West and East Vancouver, there was a fifty-fold difference in children's language and cognitive development, a seventeen-fold difference in emotional maturity, an eight-fold difference in emotional maturity, and a sixty-fold difference in nursing bottle decay.<sup>92</sup>

In sum, the environmental conditions that promote child maltreatment are strongly linked with each other and with an extraordinarily broad spectrum of serious risks to childhood development and adult well-being. The level and multiplicity of these risks demonstrate the difficulty of treatment after harm has occurred. Our knowledge of the environmental conditions that promote child maltreatment also provides risk data on which preventive strategies could be modeled.

#### *b. Limitations of Preventive Strategies*

Effective maltreatment prevention is impeded by a number of difficulties, however. The first is measurement:

. . . A key challenge . . . has been the difficulty in measuring behavior that does not occur. While the crux of prevention lies in avoiding negative outcomes, decreases in what are relatively rare behaviors even among high risk groups is difficult, particularly when these behaviors are ones the subject is likely to hide.<sup>93</sup>

A second, probably larger, difficulty lies in the fact that most of the risk factors associated with child maltreatment are behavioral. The successful innovations of the public health movement – water purification, disease immunization, mosquito eradication, food fortification, and slaughterhouse inspection – all worked because they

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<sup>90</sup> Ruth Annis, "*Think Locally, Act Globally*" Revisited: Finding Better Ways to Protect Children and Youth in B.C. 25, (British Columbia Provincial Court Judge's Assoc. Conference, 2002), available at <http://www.cecw-cepb.ca/DocsEng/RuthAnnisSpeechToBCPCJA.pdf>.

<sup>91</sup> *Id.*

<sup>92</sup> *Id.*

<sup>93</sup> See BLENDING PERSPECTIVES, *supra* note 79, at 89.

altered the environment in which disease flourished. More recent public health campaigns that have aimed to alter individual behavior have been markedly less successful than these environmental campaigns: smoking-induced diseases have declined, but have not been eradicated; seat belt use has reduced automobile injuries and fatalities, but many still fail to wear seatbelts. Public health campaigns aimed at more complex behaviors, for example, the exercise and eating patterns that fuel diabetes and related physical disorders, have floundered altogether.

Behavior-focused public health campaigns have been less successful than environmental efforts for the simple reason that behavior is hard to change. Many smokers want to quit and the obese almost invariably want to lose weight, but they often lack the capacity to alter long-standing habits.

The prevention strategies typically applied to behaviorally induced diseases are also poorly adapted to the problem of child maltreatment. The most common strategies are financial incentives such as taxation and public education. But parents who maltreat their children make no related purchases that can be taxed, and their actions are typically induced by frustration and poor judgment, not the mistaken impression that they are doing the right thing.

Of course, there is one environmental variable – poverty – that is consistently associated with child maltreatment and a range of other developmental risks. Most industrialized nations also commit far more of their public resources to reducing children's poverty than does the United States,<sup>94</sup> and countries with low children's poverty rates also tend to have low maltreatment and foster-care rates. For example, the United States, where about fifteen percent of children live in poverty,<sup>95</sup> has seventy-five per ten thousand children in state care, while Norway, with about four percent of children living in poverty, has a placement rate approximately half that level.<sup>96</sup>

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<sup>94</sup> As a result, the U.S. has one of the highest childhood poverty rate among industrialized nations. See SHEILA B. KAMERMAN ET AL., *SOCIAL POLICIES, FAMILY TYPES, AND CHILD OUTCOMES IN SELECTED OECD COUNTRIES 12* (OECD, 2003), available at <http://www.oecd.org/dataoecd/26/46/2955844.pdf>.

<sup>95</sup> See U.S. BUREAU OF THE CENSUS, *STATISTICAL ABSTRACT OF THE UNITED STATES 2003* 465 tbl. 701 (15.6% of U.S. children were in poverty in 2001).

<sup>96</sup> See Statistics Norway, available at [http://www.ssb.no/barneverng\\_en/tab-2004-08-25-06-en.html](http://www.ssb.no/barneverng_en/tab-2004-08-25-06-en.html). (reporting that, at the end of 2000, there were fifty-one hundred children in care; fifty-four percent were classified as involving conditions in the home

However, the link between poverty and child maltreatment is indirect and poorly understood.<sup>97</sup> Child maltreatment occurs in families that are not poor, and among poor families maltreatment is an extremely rare behavior. Even with respect to cognitive development and school success, where the evidence linking poverty and disadvantage is perhaps strongest, income may be a weaker outcome predictor than parental occupation.<sup>98</sup> Some experts also believe that most of the risk to children associated with family poverty results from the parental characteristics that lead to low income, characteristics that a poverty-prevention strategy cannot cure.<sup>99</sup> Indeed, even the link between poverty and placement is nonlinear; for example, the U.K. has a childhood poverty rate several times that of Norway, but a fairly comparable placement rate.<sup>100</sup>

In sum, the research data suggest that poverty reduction might play a useful role in an effective maltreatment prevention campaign, but do not demonstrate that poverty reduction offers the “silver bullet” that we would like to find.<sup>101</sup> Sadly, the data also suggest that we are not likely

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and special needs, twenty percent as the child’s behavior problems, and twenty-two percent as “other”).

<sup>97</sup> See generally Mary Keegan Eamon & Rachel M. Zuehl, *Maternal Depression and Physical Punishment as Mediators of the Effect of Poverty on Socioemotional Problems of Children in Single-Mother Families*, 71 AM. J. ORTHOPSYCHIATRY 218 (2001) (data from a national sample of 878 individuals, each forty-nine years of age. in single-mother families were used to test a structural model of the effect of poverty on children’s socioemotional problems. Results showed that the effect of poverty is mediated by maternal depression and mothers’ use of physical punishment. Maternal depression influenced children’s socioemotional problems directly, and indirectly through physical punishment).

<sup>98</sup> See Greg J. Duncan & Jeanne Brooks-Gunn, *Income Effects Across the Life Span: Integration and Interpretation*, in 596 CONSEQUENCES OF GROWING UP POOR 596-608 (Greg J. Duncan & Jeanne Brooks-Gunn eds., 1997).

<sup>99</sup> See, e.g., SUSAN E. MAYER, WHAT MONEY CAN’T BUY: FAMILY INCOME AND CHILDREN’S LIFE CHANCES 2 (1997).

<sup>100</sup> In 2003, the U.K., with a population of close to sixty million people, had 60,800 children in care, but ten percent were resident in their parents homes (.0009). U.K. NAT. STATISTICS, NATIONAL POPULATION ESTIMATES, available at <http://www.statistics.gov.uk/cci/nugget.asp?id=6> (last visited June 15, 2004); Placements of looked after children on 31 March 2003, available at [http://www.baaf.org.uk/info/stats/all\\_lac\\_stats.pdf](http://www.baaf.org.uk/info/stats/all_lac_stats.pdf).

<sup>101</sup> Even for reducing children’s poverty, “there seems to be a general consensus among scholars that income transfers (cash and tax benefits) are key . . . [.] but all agree, too, . . . [on] the need for other interventions as well, both employment-related interventions (including policies that promote maternal employment) and services (child care or early childhood education and care) that enhance child development, help reconcile work and family life, and facilitate maternal employment.” KAMERMAN ET AL., *supra* note 94, at 17.

to find such a panacea: We cannot vaccinate against maltreatment, and there is no one-dimensional disease vector directly related to maltreatment that we can alter. The parental behaviors that contribute to maltreatment are non-volitional and highly resistant to incentive-based campaigns. The environmental factors contributing to child maltreatment are complex and poorly understood.

*c. Assessing Prevention Possibilities*

Despite these limitations on maltreatment prevention, the evidence suggests that preventive strategies should receive far more attention and funding than they currently do. First, although international comparisons are risky in light of programmatic and definitional differences, there is a good deal of evidence that the United States has a child maltreatment rate well above the norm for wealthy, industrialized countries. Undeniably, childhood mortality rates in the United States are among the highest in the industrialized world.<sup>102</sup> Extrapolating from this fact, a recent United Nations survey found that children raised in the United States, Mexico, and Portugal had the greatest chances of dying from neglect or other forms of mistreatment among the twenty-seven industrialized nations that make up the Organization for Economic Cooperation and Development (OECD).<sup>103</sup> Indeed, the calculated death rate in the United States was twelve times higher than that of countries with the lowest death rates and three to four times that of countries with average records.<sup>104</sup> The United States thus appears to have an elevated rate of maltreatment that appropriate preventive measures could reduce.

Second, because child maltreatment is associated with a number of other serious risks to child development, it is altogether possible that maltreatment prevention efforts might have desirable “spill-over” effects. If maltreatment risk is strongly associated with other serious risks to cognitive, emotional, and physical development,<sup>105</sup> then a successful preventive strategy for maltreatment may also produce significant reductions in these related risks. Viewed from this

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<sup>102</sup> See Suzanne M. Smith et al., *Injury and Child Abuse in 299 FROM DATA TO ACTION 301* (U.S. Centers for Disease Control Public Health Surveillance for Women, Infants, and Children 1994), available at <http://www.cdc.gov/reproductivehealth/dataoact/pdf/Chlt4.pdf>.

<sup>103</sup> Duncan & Brooks-Gunn, *supra* note 98.

<sup>104</sup> See UNICEF, *A LEAGUE TABLE OF CHILD DEATHS BY INJURY IN RICH NATIONS*, Innocenti Report Card No.2 (Feb. 2001), available at <http://www.unicef-icdc.org/publications/pdf/repcard2e.pdf>.

<sup>105</sup> See sources cited *supra* note 38.

perspective, the fact that maltreatment and other childhood risks are highly clustered presents opportunity as well as challenges. This clustering suggests that even quite costly prevention strategies might be cost-effective if analyzed in terms of the full risk spectrum. It also points to the need for research that does not focus exclusively on maltreatment (or any other single risk to child development), but instead takes account of all associated risk factors.

Third, we do not forgo preventive efforts for physical illness because the available strategies are imperfect. The high cost and often incurable nature of the illnesses that result from risks such as smoking ensure the utility of even highly flawed prevention efforts. From a cost-benefit perspective, prevention is still crucial. The high cost and often incurable nature of the problems associated with child maltreatment make prevention equally crucial. Indeed, one can argue that the tendency of child maltreatment to repeat itself inter-generationally makes prevention efforts even more important than they are in the arena of physical illness.

Despite all these arguments supporting the viability and need for maltreatment prevention, it currently receives little attention.<sup>106</sup> Child protection agencies become involved with families only when they receive a report of suspected maltreatment. Neither child protection agencies nor any other governmental entity concentrates its efforts on reducing the risks that perpetuate our high rate of abuse and neglect.<sup>107</sup> Although the federal Family Preservation and Family Support Services program has provided funding for preventive services since 1993,<sup>108</sup> it has never received substantial funding and its preventive mandate has now been diluted with amendments that extend the program's reach to

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<sup>106</sup> See VIOLENCE IN FAMILIES, *supra* note 81, at 15 ("Identification and treatment interventions predominate over preventive strategies"); Robert A. Hahn et al., *First Reports Evaluating the Effectiveness of Strategies for Preventing Violence: Early Childhood Home Visitation: Findings from the Task Force on Community Preventive Services*, 52 MMWR 1, 1 (Oct. 2003), available at <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5214a1.htm>.

<sup>107</sup> See URBAN INSTITUTE, THE COST OF PROTECTING VULNERABLE CHILDREN: WHAT FACTORS AFFECT STATES' FISCAL DECISIONS? fig. 1 (Nov. 2002), available at <http://www.urban.org/urlprint.cfm?ID=7989> (finding that states were spending relatively little on prevention); R. BESS ET AL., URBAN INSTITUTE, THE COST OF PROTECTING VULNERABLE CHILDREN II: WHAT HAS CHANGED SINCE 1996 18 (2001), available at <http://newfederalism.urban.org/html/op46/coca46.html> (reporting that, in 1998, states expended \$4.5 billion in federal funds for out-of-home placements, \$686 million for adoption, \$412 million for administration, and \$707 million for all other services to child welfare clients).

<sup>108</sup> Omnibus Budget Reconciliation Act of 1993, Pub. L. 103-66, 107 Stat. 312, codified at 42 U.S.C. tit. IV-B(2) (1993).



post-placement and other services.<sup>109</sup> Were we to utilize a similar strategy for, say, smoking-related diseases such as lung cancer and emphysema, we would place little emphasis on smoking and smoke-exposure prevention and concentrate instead on the expensive, difficult, and often futile task of disease treatment.

To be fair, policy makers do pay greater heed to prevention than they once did. As noted at the beginning of this section, the U.S. Centers for Disease Control now classifies child maltreatment as a public health problem and has various maltreatment prevention research projects underway.<sup>110</sup> So do the National Institutes of Health (NIH); indeed, this year's NIH child abuse and neglect working group focused on "Child Maltreatment Prevention: Promising Research and Innovations."<sup>111</sup> It is time to build on this excellent beginning and develop a comprehensive prevention strategy.

#### *D. Prevention that Works: Early Childhood Education*

Although far more research is necessary before a comprehensive strategy can be outlined, there is one prevention method - early childhood education - that has been shown in a number of high-quality studies to both reduce maltreatment rates and improve academic attainment. Early education programs, including the publicly funded Head Start program, have repeatedly been found to produce cognitive advantages that lead to lower levels of special education and grade retention. Children who have experienced such programs also exhibit better classroom behavior and higher levels of social adjustment.<sup>112</sup>

<sup>109</sup> These changes derive from the Safe and Stable Families Amendments of 2001, Pub. L. 107-133, 15 Stat. 2413, which amended the definition of family support services in the "Promoting Safe and Stable Families" program legislation to include the strengthening of parental relationships and the promotion of healthy marriages. It also amended the definition of family preservation services to allow states to support infant safe haven programs. Although states could always use the funds for these services, the amendment clarified their flexibility to do so. Additionally, the bill added two new permissible services, mentoring children of prisoners and assistance to former foster children.

<sup>110</sup> See Rodney W. Hammond, *Public Health and Child Maltreatment Prevention: The Role of the Centers for Disease Control and Prevention*, 18 *CHILD MALTREATMENT* 81, 81 (2003).

<sup>111</sup> U.S. DEPT. OF HEALTH AND HUMAN SERVICES, *AGENDA, CHILD MALTREATMENT PREVENTION: PROMISING RESEARCH AND INNOVATIONS* (2004), available at <http://www.nimh.nih.gov/scientificmeetings/canwg2004agenda.pdf>.

<sup>112</sup> U.S. Dept. of Health & Human Services, *EARLY HEAD START BENEFITS CHILDREN AND FAMILIES* (1999), available at [http://www.acf.hhs.gov/programs/opre/ehs/ehs\\_resrch/reports/dissemination/research\\_briefs/research\\_brief\\_overall.pdf](http://www.acf.hhs.gov/programs/opre/ehs/ehs_resrch/reports/dissemination/research_briefs/research_brief_overall.pdf) [hereinafter *EARLY HEAD START BENEFITS*].

Evaluations of Early Head Start programs focused on children under the age of three have also found positive impacts on children's cognitive, language, motor, and social-emotional development and on their parents' provision of learning support and parenting behavior. Importantly, these impacts appear to be more than transitory.<sup>113</sup>

Given the association between delayed cognitive development and maltreatment risk, it should not surprise us that high-quality early education has also been shown to reduce the incidence of child maltreatment, at least if the educational program is coupled with family services and parental involvement. Researchers studying the impact of the Chicago School District's Child-Parent Center (CPC) initiative compared child maltreatment rates of children who participated in a CPC preschool program with a control group who did not attend the program but did attend full-day kindergarten. They also examined the effects of extended participation at a CPC, which can continue to third grade. They found that, between the ages of four and seventeen, children who attended the preschool intervention program had a maltreatment rate fifty-two percent lower than that of the control group. They also found that children enrolled for more than four years experienced a forty-eight percent lower rate of maltreatment than those enrolled between one and four years.<sup>114</sup>

Significantly, the CPC research is well-designed and employs a carefully matched control group. While the researchers could not screen out the possible impact of parents' voluntary participation in CPC, they were able to control for a wide range of other variables. The quality of the research strongly supports further investment in programs of this type.

The CPC program is intensive and multi-faceted. It stresses individualized learning. It requires parental participation and provides outreach services, including home visits and referrals to appropriate social services agencies for parents, as well as health screening and free

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<sup>113</sup> See U.S. ADMIN. FOR CHILDREN & FAMILIES, U.S. DEPT. OF HEALTH & HUMAN SERVICES, EVALUATING HEAD START: A RECOMMENDED FRAMEWORK FOR STUDYING THE IMPACT OF THE HEAD START PROGRAM, <http://www2.acf.dhhs.gov/programs/hsb/research/hsreac/1999report/chapter3.htm> [hereinafter EVALUATING HEAD START].

<sup>114</sup> See A.J. Reynolds & D.L. Robertson, *School-Based Early Intervention and Later Child Maltreatment in the Chicago Longitudinal Study*, 74 CHILD DEVELOPMENT 3, 14 (2003); A.J. Reynolds et al., *School-Based Early Intervention and Child Well-Being in the Chicago Longitudinal Study*, 82 CHILD WELFARE 633 (2003).

meals for children.<sup>115</sup> Less intensive early-intervention programs, including those that offer services without an educational component, appear to be considerably less successful than the CPC program. Although so-called “home visiting” programs that provide pre- and post-natal family services to high-risk families have also shown significant benefits in some low-income populations,<sup>116</sup> a recent “review of reviews” found “inconclusive evidence” of an impact on child abuse, “some evidence” of cognitive benefits, “some good evidence” of a positive impact on parenting, and “good evidence” of an impact on injuries.<sup>117</sup> It also found that the research data supported visiting programs with a “comprehensive approach” addressing the “multiple needs” of families instead of programs “restricted to the pursuit of only a narrow range of outcomes.”<sup>118</sup> Thus, while it appears that home-visiting programs are worthwhile, at least for some clients, it also appears that

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<sup>115</sup> The service component of the CPC program is undoubtedly a major reason for the program’s striking success rate. In other studies of early childhood education, children with many risk factors tend to be the ones who do not benefit. In the Early Head Start evaluation, positive effects were not found among families who had extremely high numbers of demographic risk factors (i.e., with four or five of the following factors: lacked a high school education, was a single parent, was a teen parent, received public assistance, and was not employed or in school). See EVALUATING HEAD START, *supra* note 113.

<sup>116</sup> See David Olds et al., *Long-Term Effects of Nurse Home Visitation on Children’s Criminal and Antisocial Behavior: 15-Year Follow-up of a Randomized Controlled Trial*, 280 JAMA 1238, 1238 (1998) (finding that “adolescents born to women who received nurse visits during pregnancy and postnatally and who were unmarried and from households of low socioeconomic status (risk factors for antisocial behavior), in contrast with those in the comparison groups, reported significantly fewer instances . . . , of running away . . . , fewer arrests . . . , fewer convictions and violations of probation . . . , fewer lifetime sex partners . . . , fewer cigarettes smoked per day . . . , and fewer days having consumed alcohol in the last 6 months”); Harriet Kitzman et al., *Enduring Effects of Nurse Home Visitation on Maternal Life Course: A 3-Year Follow-Up of a Randomized Trial*, 283 JAMA 1983, 1983 (2000) (finding significant impact on number and spacing of subsequent children as well as welfare participation).

<sup>117</sup> EARLY HEAD START BENEFITS, *supra* note 112.

<sup>118</sup> JULIE BULL ET AL., ANTE- AND POST-NATAL HOME-VISITING PROGRAMMES: A REVIEW OF REVIEWS EVIDENCE BRIEFING 3 (Health Development Agency, 1st ed., Feb. 2004), available at [http://www.hda.nhs.uk/documents/home\\_visiting.pdf](http://www.hda.nhs.uk/documents/home_visiting.pdf). See also Deanna S. Gombay, *Promise and Limitations of Home Visitation*, 284 JAMA 1430, 1431 (2000) (reporting “enormous variability in outcome for many home-visitation programs; results vary widely across program goals, program models, program sites, and across families within the same site” and concluding that “universal home-visitation services are unlikely to produce large benefits for all families”).

their impact is greatest when they are part of an intensive and comprehensive program of early childhood education.<sup>119</sup>

The CPC program also appears to be cost-effective. The various services provided by CPC add up to a per-child price tag of about \$6,692, generating a return of \$47,795 per-participant.<sup>120</sup> Researchers have calculated that, as a result of reduced use of remedial education services, fewer arrests, and higher taxes paid by high school graduates, the program still produces government savings of about eleven thousand dollars per child over six years.<sup>121</sup> Note that these calculations exclude the cost of intervention by child protection agencies and the potential savings from preventive health care. It is thus likely that the calculated gains are conservative. Indeed, some experts argue that good quality early childhood programs for low-income children can save as much as seven dollars for every single dollar spent simply by increasing the likelihood that children will not be arrested or become welfare-dependent and that they will be literate, graduate from high school, and obtain employment.<sup>122</sup>

Early childhood education programs like CPC are not panaceas, and much more research is needed to determine optimal program design and the impact of factors like parental involvement and multiple risks. It may be that special, even more intensive, strategies are necessary for families with a very large number of risks. It may be that parents who

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<sup>119</sup> See, e.g., FROM NEURONS TO NEIGHBORHOODS: THE SCIENCE OF EARLY CHILDHOOD DEVELOPMENT 11 (Jack P. Schonkoff & Deborah A. Phillips eds., 2000) (“Early childhood programs that deliver carefully designed interventions with well-defined objectives and that include well-designed evaluations have been shown to influence the developmental trajectories of children whose life course is threatened by socioeconomic disadvantage, family disruption, and diagnosed disabilities. Programs that combine child-focused educational activities with explicit attention to parent-child interaction patterns and relationship building appear to have the greatest impacts. In contrast, services that are based on generic family support, often without a clear delineation of intervention strategies matched directly to measurable objectives and that are funded by more modest budgets, appear to be less effective”).

<sup>120</sup> See Early Childhood Focus, *Cost-Benefit Analysis of Chicago Child-Parent Center Program Released (May 7, 2004)*, available at <http://www.earlychildhoodfocus.org/modules.php?name=News&file=article&sid=1854>.

<sup>121</sup> See STRATEGIES FOR CHILDREN, RESEARCH SUMMARY OF MAJOR LONGITUDINAL STUDIES ON THE BENEFITS OF EARLY CHILDHOOD EDUCATION (Dec. 2002), available at <http://www.strategiesforchildren.org/images/pdfs/Summary%20of%20Major%20Longitudinal%20Studies.pdf>.

<sup>122</sup> See CHILDREN'S DEFENSE FUND, HEAD START: HELPING CHILDREN LEARN AND SUPPORTING FAMILIES 158 (2003), available at [http://www.childrensdefense.org/earlychildhood/headstart/keyfacts2003\\_headstart.pdf](http://www.childrensdefense.org/earlychildhood/headstart/keyfacts2003_headstart.pdf).

are a reluctant to accept help cannot be assisted through programs of this type.

However, we have enough evidence to show that investments in high-quality early education can and do yield substantial benefits both in terms of reducing maltreatment and enhancing children's prospects of academic success. These proven benefits have led many industrialized nations to offer at least this component of the CPC program not just to low-income and welfare-eligible families, but to all. The evidence suggests that they are reaping major benefits from doing so.

In the United States, however, publicly funded early education is available only to low-income children and reaches a relatively small proportion of those eligible. Head Start reaches only about sixty percent and Early Head Start just three percent of eligible children.<sup>123</sup> Moreover, Head Start dollars typically cover only the cost of part-day, part-year programs. Currently, only thirty-nine percent of children are enrolled five days a week on a full-day basis, and even "full-day" services are unlikely to extend beyond the six-hour school day or throughout the year.<sup>124</sup>

An effective child maltreatment prevention program would alter these patterns. It would treat CPC-like programs as an important component of child protection. It would provide funds for further research aimed at maximizing their effectiveness and fund successful programs fully.

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<sup>123</sup> CHILDREN'S DEFENSE FUND, HEAD START REAUTHORIZATION: QUESTIONS AND ANSWERS 5 (2003), available at [http://www.childrensdefense.org/earlychildhood/headstart/reauthorization\\_q&a.pdf#xml=http://childrensdefense.org/master.com/taxis/master/search/mysite.txt?q=Head+Start&order=r&id=404948304191e9d&cmd=xml](http://www.childrensdefense.org/earlychildhood/headstart/reauthorization_q&a.pdf#xml=http://childrensdefense.org/master.com/taxis/master/search/mysite.txt?q=Head+Start&order=r&id=404948304191e9d&cmd=xml).

<sup>124</sup> Source on file with author. Making matters worse, the combination of rising child-care costs and static federal child-care funding is expected to result in the loss of child-care assistance to at least 300,000 children over the next few years. See JENNIFER MEEZEY ET AL., REVERSING DIRECTION ON WELFARE REFORM: PRESIDENT'S BUDGET CUTS CHILD CARE FOR MORE THAN 300,000 CHILDREN (Center on Budget & Policy Priorities, Feb. 10, 2004), available at <http://www.cbpp.org/2-10-04wel1.htm> (describing official government estimates and theorizing that official estimate "almost certainly understates the actual number of children who would lose care").

*E. Promising Prevention Strategies: Screening and Services for High-Risk Populations*

Although early childhood education appears to be the only prevention method that high-quality research has actually shown to work, there are other promising approaches. The most obvious is the provision of high-quality screening and services to high-risk parents. Certainly, most effective prevention campaigns focus on high risk populations. For example, lung-cancer prevention efforts focus on smokers, and diabetes prevention efforts focus on the obese and hypertensive.

Child maltreatment is highly correlated with substance abuse, violence between adult family members, and mental health problems; substance abuse, mental illness, and family violence are also highly correlated with each other.<sup>125</sup> The connections appear to be particularly pronounced among women, who are most likely to be reported for child maltreatment.<sup>126</sup> If we could reduce or effectively treat substance abuse, mental health disorders, and family violence – the conditions that seem to most strongly promote child maltreatment – it seems likely that we could also avert many cases of maltreatment and other associated harms. Certainly, in calculating the costs and benefits of primary prevention and treatment of these various disorders, we should take into account their links with child maltreatment and its high costs. Certainly, we should make preventive and treatment services aimed at these high-risk populations a research priority.

While this much is obvious, there are no strategies that have been shown, in high-quality research, to significantly reduce the rate of maltreatment among high-risk populations. Indeed, for domestic violence, it is not even clear that we can currently provide useful interventions. Although we have reliable screening instruments that can identify women experiencing intimate partner violence, a recent review found

no high-quality evidence . . . to evaluate [either] the effectiveness of shelter stays to reduce violence[. . . or] intervention strategies in treating both women and men . . . , primarily because of a lack of suitably

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<sup>125</sup> See *supra* text accompanying notes 79-81.

<sup>126</sup> See BLENDING PERSPECTIVES, *supra* note 79, at ch. 5 (reporting that women's rate of reported depression and other mental health problems is more than double that of men with similar levels of substance use).

designed research measuring appropriate outcomes. In most cases, the potential harms of interventions are not assessed within the studies reviewed.<sup>127</sup>

Fortunately, treatment strategies for mental illness and substance abuse are much more advanced. We do possess highly efficacious drug therapies for mental illnesses ranging from anxiety to depression to psychosis. Drug therapies for alcohol,<sup>128</sup> opiate,<sup>129</sup> and cocaine<sup>130</sup> addiction have also shown great promise. Although many forms of addiction remain difficult to treat, a number of studies suggest that perhaps as many as two-thirds of addicts in recovery eventually achieve long-term abstinence.<sup>131</sup> Various research projects also suggest that screening and treatment can have a major impact on addicts' behavior and motivation. For example, D.V. Sivkis and colleagues randomly assigned cocaine-dependent pregnant women to treatment, consisting of residential care for one week followed by twice-weekly addiction counseling, and non-treatment.<sup>132</sup> Thirty-seven percent of those in the treatment group tested positive at birth compared with sixty-three

<sup>127</sup> C. Nadine Wrathen & Harriet L. MacMilan, *Interventions for Violence Against Women*, 289 JAMA 589, 589 (2003).

<sup>128</sup> See Richard K. Fuller & Enroch Gordis, *Naltrexone Treatment for Alcohol Dependence*, 345 NEW ENG. J. MED. 1770, 1770-1771 (2001); J.R. Volpicelli et al., *Naltrexone in the Treatment of Alcohol Dependence*, 49 ARCHIVES OF GEN. PSYCHIATRY 876, 876 (1992).

<sup>129</sup> See Mori J. Krantz & Philip S. Mehler, *Treating Opioid Dependence: Growing Implications for Primary Care*, 164 ARCHIVES OF INTERNAL MED. 277, 277 (2004) (describing office-based buprenorphine treatment).

<sup>130</sup> See Kathleen M. Carroll et al., *Efficacy of Disulfiram and Cognitive Behavior Therapy in Cocaine-Dependent Outpatients*, 61 ARCHIVES OF GEN. PSYCHIATRY 264, 264 (2004) (describing use of disulfiram and cognitive therapy for cocaine addiction).

<sup>131</sup> A GAO survey found that, among surveyed substance-abusing mothers whose children had been in foster care for at least one year, about forty percent had entered treatment programs but failed to complete them, usually because of relapse. In some instances, mental illness, incarceration, or medical conditions were cited as reasons these mothers had failed to complete treatment. Less than twenty percent had either completed treatment or were currently in a treatment program. See AGENCIES FACE CHALLENGES, *supra* note 79, at 16-18.

<sup>132</sup> D.K. Sivkis et al., *Cost Effectiveness of Treatment for Drug Abusing Pregnant Women*, 45 DRUG ALCOHOL DEPENDENCY 105, 105 (1997). See also R.E. Booth et al., *Substance Abuse Treatment Entry, Retention and Effectiveness*, 42 DRUG ALCOHOL DEPENDENCY 11, 17 (1996) (describing results of random-assignment of four thousand intravenous drug users seeking HIV testing in fifteen cities to either HIV testing alone or to testing plus three sessions of motivational counseling from a health educator; at six-month follow-up, those who received additional counseling showed half the rate of drug injection (twenty percent vs. forty-five percent), four times the likelihood of abstinence (confirmed by urinalysis), and significantly lower arrest rates (fourteen percent versus twenty-four percent) than those randomly assigned to receive just HIV testing).

percent of the untreated women.<sup>133</sup> Infants of the treated women averaged significantly higher birth weights and longer gestational periods. They also required much less, and much less expensive, medical care: following delivery, only ten percent of infants in the treatment group required intensive care as compared to twenty-six percent of infants in the control group;<sup>134</sup> the average hospital stay of treatment-group infants was thirty-two days shorter and their average care costs thirty thousand dollars lower.<sup>135</sup>

To achieve long-term effectiveness, however, prevention campaigns must provide long-term support and services. A growing body of evidence suggests that substance abuse, mental illness and domestic violence are typically chronic conditions, like asthma or hypertension.<sup>136</sup> A recent review of “more than 100 randomized controlled trials of addiction treatments [found] most showing significant reductions in drug use, improved personal health, and reduced social pathology, but not cure”:

There is little evidence of effectiveness from detoxification or short-term stabilization alone without maintenance or monitoring such as in methadone maintenance or AA. However, as in treatments for other chronic disorders, we found major problems of medication adherence, early drop-out, and relapse among drug-dependent patients. In fact, problems of poverty, lack of family support, and psychiatric comorbidity were major and approximately equal predictors of noncompliance and relapse across all chronic illnesses examined.<sup>137</sup>

Because we lack effective techniques to prevent relapse, experts stress that “it is essential that practitioners adapt the care and medical monitoring strategies currently used in the treatment of other chronic illnesses.”<sup>138</sup> We thus need comprehensive, long-term treatments and

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<sup>133</sup> Svikis, *supra* note 132, at 107.

<sup>134</sup> *Id.*

<sup>135</sup> *Id.* at 110.

<sup>136</sup> A. Thomas McLean et al., *Drug Dependence, a Chronic Medical Illness: Implications for Treatment, Insurance, and Outcomes Evaluation*, 284 JAMA 1689, 1689 (2000).

<sup>137</sup> *Id.* at 1693-1694.

<sup>138</sup> *Id.* at 1694.



services designed to help high-risk parents over time, and to help those who are not yet parents before they become parents.

Although intensive, long-term preventive services for high-risk parents will undoubtedly be expensive, if these services work they will also be cost-effective. Maltreated children from substance-abusing families are more likely than others to be placed in foster care.<sup>139</sup> They have higher than average periods of stay.<sup>140</sup> They are at elevated risk for poor physical, intellectual, social, and emotional outcomes and for developing substance abuse problems themselves;<sup>141</sup> children of alcohol and drug abusing parents are at the highest risk of any children for later drug use and other adolescent behavioral health and mental health problems.<sup>142</sup>

While effective prevention programs for high-risk populations are clearly crucial, preventive services for high-risk parents now are almost nonexistent. Indeed, even parents already identified as neglectful or abusive often fail to receive needed treatment.<sup>143</sup> Thus, despite federal laws that give pregnant women and parents priority in obtaining substance-abuse treatment services and widespread Medicaid coverage for substance-abuse and alcoholism treatment,<sup>144</sup> the states continue to

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<sup>139</sup> BLENDING PERSPECTIVES, *supra* note 79, at ix.

<sup>140</sup> *Id.*

<sup>141</sup> *Id.*

<sup>142</sup> The heightened risks are thought to be due to both familial and genetic factors. See Kathleen R. Merikangas et al., *Familial Transmission of Substance Use Disorders*, 55 ARCH. GEN. PSYCHIATRY 973, 973 (1998) (reporting eight-fold increased risk of drug disorders among relatives of 299 individuals with drug disorders); Brian M. Hicks et al., *Family Transmission and Heritability of Externalizing Disorders: A Twin-Family Study*, 61 ARCH. GEN. PSYCHIATRY 922, 922 (2004) (reporting that general vulnerability to conduct disorder, the adult criteria for antisocial personality disorder, alcohol dependence, and drug dependence was “highly heritable” and that disorder-specific vulnerabilities were also detected for conduct disorder, alcohol dependence, and drug dependence).

<sup>143</sup> The percentage of patients in outpatient drug treatment programs who received parenting classes or family therapy actually declined during the decade of the 1980s from forty-three percent to 8.3%. See BLENDING PERSPECTIVES, *supra* note 79, at ch. 6 (also reporting that “even in the most service intensive modalities fewer than forty percent of clients received these services and noting “[s]imilar declines . . . in the provision of medical, psychological, legal, educational, vocational and financial services”).

<sup>144</sup> See KAISER COMMISSION, REHABILITATIONS SERVICES: MENTAL HEALTH AND SUBSTANCE ABUSE, available at <http://www.kff.org/medicaidbenefits/rehabilitation.cfm> (last visited Feb. 25, 2005) [hereinafter KAISER COMMISSION].

report that it is often difficult for high-priority addicts to access open treatment slots quickly.<sup>145</sup>

An effective child protection prevention program would alter these patterns dramatically. It would provide for mental-health and substance-abuse screening as part of routine pre- and post-natal well-child care in order to catch problems as early as possible. It would ensure that substance-abusing parents obtain prompt, integrated treatment that provide the best chance at success.<sup>146</sup> It would invest in and build on interventions, like the cocaine-treatment protocols pioneered by Sivkis and colleagues, that have already shown promise. It would develop long-term interventions that take account of the chronicity of risk conditions like mental illness and substance abuse.

#### IV. REFORMULATING CHILD PROTECTION LAW AND PRACTICE

A public health perspective on child maltreatment reveals the need for both a massive research effort and a major funding shift directed at primary prevention. It also reveals major flaws in child protection practice, law, and structure.

As we have seen, child maltreatment is strongly associated with a diverse array of developmental risks.<sup>147</sup> These associated risks enhance the difficulty of determining what harms are produced by maltreatment, treating harm that has occurred, and preventing future harm. These already large difficulties are magnified by the fact that the risk factors associated with maltreatment are complex and often chronic.

Given the epidemiological evidence, one would expect child protection practice to emphasize long-term, intensive, and multi-faceted interventions. Instead, as we have seen, it relies on a situational, "acute-care" treatment model. Just as they did in the symposium panel

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<sup>145</sup> See FINDING PERMANENT HOMES, *supra* note 15.

<sup>146</sup> See NAT'L GUIDELINE CLEARINGHOUSE, SUBSTANCE ABUSE TREATMENT FOR PERSONS WITH CHILD ABUSE AND NEGLECT ISSUES, *available at* [http://www.guideline.gov/summary/summary.aspx?ss=15&doc\\_id=2543&nbr=1769#s23](http://www.guideline.gov/summary/summary.aspx?ss=15&doc_id=2543&nbr=1769#s23) (last visited Feb. 25, 2005) (reporting that a "very important factor in predicting treatment success is the number of services clients receive (e.g., case management, parenting education, counseling for posttraumatic stress disorder and childhood abuse) and that clients "receiving more specialized services, often concurrently with substance abuse treatment, are more likely to stay in recovery").

<sup>147</sup> See *supra* text accompanying note 90.

discussion, child protection workers typically respond to incidents, but fail to assess harm, risk, and treatment needs. All too often, workers respond to maltreatment as if it were an environmental malady that can be remedied with a change of scene for the child and a set of directives for the parent; interventions are short-term, cursory, and limited to the stark choice between placement – with extremely limited services – or nothing.

Current child protection law reflects the same acute-care mentality. The AACWA does require case planning and review, but it fails to require – for either the maltreated child or maltreating parent – diagnostic assessment, evidence-based treatment, or post-placement care. Making matters worse, ASFA requires the states, in many cases, to terminate parental rights within fifteen months of placement.<sup>148</sup>

Law and practice thus work together to preserve the patterns of failure that researchers have observed for decades. It should not surprise us that children reunited with their parents often return, fairly quickly, to foster care.<sup>149</sup> Nor should it surprise us that foster care prevention projects have typically floundered and that even those children who stay at home without returning to foster care often fare badly.<sup>150</sup> Given the chronic nature of child maltreatment risk and the limited, short-term interventions that are offered, what else would we expect?

To improve these results, child protection law and practice must be revised to reflect the multifaceted and long-term nature of maltreatment risk. As in the treatment of diabetes, hypertension, and addiction, “treatment needs to be readily available; . . . [counterproductive behavior] during treatment needs to be monitored . . . ; individuals with comorbid mental illnesses need to receive integrated treatment for both disorders.”<sup>151</sup> Both law and practice must also take account of the fact that no “single treatment is appropriate for everyone” and recognize that complete recovery – for both parent and child – “is a long-term process that often requires multiple treatment episodes.”<sup>152</sup>

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<sup>148</sup> See 42 U.S.C. §§ 671(a)(15)-(16), 672(a)(1)-(2), 675(5)(B) (2005).

<sup>149</sup> See text accompanying *infra* note 156.

<sup>150</sup> *Id.*

<sup>151</sup> Brian Vastag, *Addiction Poorly Understood by Clinicians*, 290 JAMA 1299, 1303 (2003) (summarizing recommendations of consensus guidelines contained in Principles of Drug Addiction Treatment).

<sup>152</sup> *Id.*

Changing current child-protection response patterns will not be easy. These patterns are deeply embedded within child welfare practice and reflect the widespread supposition that child maltreatment represents volitional misconduct instead of a complex behavioral disorder. They are also reinforced by federal funding formulae. Under current law, the federal government reimburses the states for foster care placements of income-eligible children.<sup>153</sup> The provision of diagnostic, treatment, and post-placement services does not trigger reimbursement, and foster care funds are often insufficient to pay for these crucial tools. Medicaid partially fills this gap. So does the relatively new Children's Health Insurance Program (CHIP). However, the fact that Medicaid-eligible parents often experience lengthy waits for substance-abuse treatment suggests that reimbursement levels are inadequate to stimulate the necessary level of provider investment.<sup>154</sup> The federal funding formula also tends to discourage the provision of services, since reimbursement is conditioned simply on the fact of placement. Making matters worse, ASFA rewards the states for adoptions,<sup>155</sup> but no federal law rewards, or even provides incentives, for diagnostic assessment and individualized treatment before, during, or after foster care. Federal law neither penalizes the states for failing to achieve improvements in child and

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<sup>153</sup> See 42 U.S.C. § 672 (2005). The federal funding formula limits reimbursement to "maintenance", i.e., payments made to licensed foster parents, group homes and residential child care facilities, administration (i.e., case review, rate setting, recruitment and licensing, etc.), and staff training. For children that are Title IV-E eligible, the federal government reimburses the state for fifty to eighty-three percent of maintenance costs; a state's reimbursement percentage is the same as its Medicaid reimbursement percentage and is based primarily on per capita income; the higher the state's per capita income, the lower the reimbursement rate. If the child is not Title IV-E eligible, the state is responsible for all costs associated with her care. Administrative and training reimbursement is calculated on a different basis than maintenance reimbursement. See CHILD WELFARE LEAGUE OF AMERICA, OVERVIEW OF TITLE IV-E FOSTER CARE PROGRAM, available at <http://www.cwla.org/advocacy/overviewtitleIV-E.htm> (last visited Mar. 18, 2005).

<sup>154</sup> See BLENDING PERSPECTIVES, *supra* note 79; KAISER COMMISSION, *supra* note 144; FINDING PERMANENT HOMES, *supra* note 15.

<sup>155</sup> See 42 U.S.C. § 673b(d)(1) (2005) (providing "\$4,000, multiplied by the amount (if any) by which the number of foster child adoptions . . . exceeds the base number" and an additional \$2,000 for "special needs adoptions"). In 2000, Congress enacted the Strengthening Abuse and Neglect Courts Act of 2000 ("SANCA") to facilitate ASFA's goal of rapid exits from foster care. SANCA provides federal funds for training "judges, court personnel, agency attorneys, guardians ad litem, volunteers . . . and attorneys who represent children", case tracking, and expansion of the court-appointed volunteer programs. Strengthening Abuse and Neglect Courts Act of 2000, Pub. L. No. 106-314, 114 Stat. 1266 (2000).

parental functioning nor does it reward success.<sup>156</sup> It does not penalize the states for revolving-door care. It fails to mandate or even encourage high-quality research.

Although a model federal-funding formula is well beyond the scope of this article, a formula that severs the link between placement and reimbursement is certainly desirable. So is an incentive structure that mandates or rewards diagnostic assessment, including addiction, domestic violence, and mental health screening, treatment plans tailored to diagnosed treatment needs, and the provision of services that are integrated and long-term.

Federal law should also mandate high-quality state research programs to improve current prevention and treatment protocols. Today, very few states have ongoing research programs. The federal government offers no financial incentives or rewards for implementing research programs or even for achieving reductions in long-term foster care as a result of successful research. Indeed, because federal aid is linked specifically and solely to placement, research like that described by Professor Testa – research with the potential to greatly improve placement success – is probably deterred: why should state officials bother if their source of funds is uninterested? If the federal government mandated research programs and rewarded research success, the current lackadaisical attitude would likely shift immediately and sharply.

Federal law should couple state-based research efforts with the collection of data on child-protection client and treatment characteristics. Differences in treatment protocols for similar populations provide the opportunity to evaluate the efficacy of those treatments. This kind of research is now common in testing the benefits of drugs and other medical therapies.<sup>157</sup> Indeed, since 1992, the Federal Health Care Financing Administration (HCFA), which funds the Medicare program, has implemented a continuous quality improvement approach that makes use of such comparative data to develop practice guidelines and monitor

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<sup>156</sup> “It does not matter whether the . . . agencies turn out every teen to homelessness or to a four-year university; the funding remains the same, and all agencies are eligible to take teens again the next year.” Betsy Krebs & Paul Pitkoff, *Reversing the Failure of the Foster Care System*, 27 HARV. WOMEN’S L.J. 357, 359 (2004).

<sup>157</sup> See, e.g., Ulf Stenesrand et al., *Early Statin Treatment Following Acute Myocardial Infarction and 1-Year Survival*, 285 JAMA 430, 430 (2001) (using Swedish hospital data); O’Connor et al., *supra* note 66, at 627.

adherence to them.<sup>158</sup> The fiscal and quality-assurance concerns that drive the HCFA to make use of comparative data are no less important in child welfare work.

Finally, federal law should both provide maltreated children with an entitlement to appropriate services and require federally funded and private health insurers to cover these services – at adequate reimbursement levels – following a maltreatment finding. The child protection system’s failure to utilize an appropriate medical treatment model reflects, at least in part, the fact that at-risk children and their families often lack access to appropriate medical care.<sup>159</sup> The large number of poor families without health insurance contributes to this access problem,<sup>160</sup> as do bureaucratic barriers that discourage families from enrolling in federal means-tested programs and low reimbursement rates that discourage provider participation.<sup>161</sup> Of course, the most efficient means of providing the services needed by maltreated children would be a health care system that provided universal coverage to all Americans;<sup>162</sup> such a system would encourage preventive care and might even avert some instances of maltreatment.<sup>163</sup> Until such a system is in

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<sup>158</sup> See S.F. Jencks & G.R. Wilensky, *The Health Care Quality Improvement Initiative: A New Approach to Quality Assurance in Medicare*, 268 JAMA 900, 900-903 (1992).

<sup>159</sup> Although children in foster care are almost invariably eligible to receive Medicaid, one group of researchers has reported that sixteen percent of surveyed children had been uninsured at some time in the past year and that many received no preventive care: “Only 7 percent of child-welfare-involved children have no usual source of care or their usual source is the hospital emergency room; however, far more have not received preventive care. Twenty-seven percent of 0- to 5-year-olds, 21 percent of 6- to 11-year-olds, and 40 percent of 12- to 17-year-olds received no well-child health care in the past year. In addition, 37 percent of 3- to 17-year-olds did not visit the dentist in the past year.” KORTENKAMP & MACOMBER *supra* note 38, at *Health and Health Care*.

<sup>160</sup> In 2003, 19.2% of U.S. children in poverty were uninsured. See CARMEN DE NAVAS WALT ET AL., INCOME, POVERTY, AND HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2003, 14 (Current Pop. Rpts. P60-226, 2004).

<sup>161</sup> See John M. Eisenberg & Elaine J. Power, *Transforming Insurance Coverage Into Quality Health Care: Voltage Drops From Potential to Delivered Quality*, 284 JAMA 2100, 2102 (2000).

<sup>162</sup> Forgone preventive care often produces avoidable — and very large — health care expenses. For example, 12.4% of U.S. mothers received inadequate prenatal care in 1996. Inadequate prenatal care contributes to low birth-weight, which is associated with a vast array of debilitating and expensive medical complications. Even if we ignore the long-term expenses associated with low birth-weight, neonatal hospital care for these tiny infants costs from \$200,000 to \$400,000, as compared to \$6,400 for an uncomplicated full-term delivery. See Joel E. Frader, *Baby Doe Blinders*, 284 JAMA 1143, 1143 (2000).

<sup>163</sup> Among low-income individuals in poor health, poor access to medical care leads to less preventive care and worse health outcomes. See John Z. Avanian et al., *Unmet*

place, federal law should at least guarantee that maltreated children have access to the health care services that they need.

## V. CONCLUSION

The fact that all maltreated children do not have health insurance brings us to another – perhaps the most important – issue. Consistently, we have seen that the United States lags well behind its peers among advanced, industrialized countries.<sup>164</sup> Inadequate services to high-risk populations, lack of publicly funded early childhood education and care, and low levels of economic support for children, all reflect a broader cultural pattern; virtually across the board, we expect families to provide for themselves. This self-help mentality is not confined to the child welfare context. Uniquely among developed countries, the United States offers no guarantee of access to basic health care. Nor, as is typical, does it provide funding to qualified students for higher education or income transfers to reduce wealth disparities. Even the highly successful WIC program, which a skeptical Congress reauthorized after a federal meta-analysis of all WIC evaluations demonstrated clear and cost-effective benefits to infant nutrition and health,<sup>165</sup> remains chronically underfunded.

Only the elderly have escaped this culture of self-help. Over the same period in which children's poverty skyrocketed, that of the elderly declined markedly. These divergent poverty trends reflect contrasting government policies. As children's poverty rate rose during the 1970s and 1980s, U.S. legislators focused almost exclusively on child support – private transfers between parents – as a remedy. During the same period, the elderly were the beneficiaries of inflation-adjusted Social Security payments and universal health care coverage through the Medicare program.<sup>166</sup> The ultimate result is an elderly poverty rate

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*Health Needs of Uninsured Adults in the United States*, 284 JAMA 2061, 2061 (2000); G. Solanki et al., *The Direct and Indirect Effects of Cost-sharing on the Use of Preventive Services*, 34 HEALTH SERVICE RESEARCH 1331, 1331 (2000).

<sup>164</sup> See Marsha Garrison, *Book Review*, 28 FAM. L.Q. 475, 505-07 (1994) [hereinafter *Book Review*] (summarizing evidence).

<sup>165</sup> Congress subsequently disbanded the GAO division that performed this analysis; it also abolished the Congressional Office of Technology Assessment, another evidence-based office providing information for policy to the federal government. See Steven B. Thacker, *Meta-analysis*, 279 JAMA 244, 244 (1998) (reviewing MORTON HUNT, *HOW SCIENCE TAKES STOCK: THE STORY OF META-ANALYSIS* (1997)).

<sup>166</sup> See *Book Review*, *supra* note 164, at 505-07 (1994) (summarizing evidence).

consistent with or lower than those of other industrialized nations and a children's poverty rate like that of a third-world country.<sup>167</sup>

Social Security and Medicare remain sacrosanct entitlements: politicians on both sides of the party fence vie to demonstrate allegiance to each program; they are willing to vote for and fund expanded benefits such as the new prescription drug entitlement. The reason for this enthusiasm is, of course, demographic. The elderly constitute a large and increasing slice of the population, and they are a slice that votes regularly and in large numbers.

Given the importance of the senior vote to both political parties and the high cost associated with maintaining senior citizens' current entitlements, it is far from obvious that new funding for child protection will materialize. And let us make no mistake: Nothing that is needed is cheap.

Thus, while the evidence suggests that the current crisis in child protection will not be ameliorated without significant investments, it is far from obvious that legislators will choose to fund the kind of programs that will be necessary. Indeed, I was fascinated to run across a 1993 United States government publication urging funding for all of the preventive efforts I have identified and more. This publication concludes with an acknowledgment that

[t]he remedying of child neglect will be costly, but the costs of not providing the needed preventive and remedial services are also great. The cost of neglected children who will suffer severe learning deficits, school failure, and lost earning potential alone is enormous. Add to that the costs of foster care, crime and delinquency, economic dependency, and the next generation of parents unable to provide adequate care for their children is even more costly to society.<sup>168</sup>

Since 1993, little has changed.

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<sup>167</sup> See WALT ET AL., *supra* note 160, at 10 (reporting 2003 children's poverty level of 17.6% and elderly poverty rate of 10.2% and showing divergence in elderly and children's poverty rates since the 1970s).

<sup>168</sup> U.S. ADMIN. FOR CHILDREN & FAMILIES, U.S. OF HEALTH & HUMAN SERVICES, CHILD NEGLECT: A GUIDE FOR INTERVENTION § 6 (1993), available at <http://nccanch.acf.hhs.gov/pubs/usermanuals/neglect/neglectcf.cfm>.



Nothing will change unless child protection somehow obtains public support like that which protects Social Security and Medicare.<sup>169</sup> In a review of opinion polls on children's health, researchers describe their "most striking" finding as "the limited concern expressed for the [two] problems that many experts consider being among the most important":

Childhood poverty affects 1 in 5 children, but constituted 2% of the problems the public identified; problems children have getting health care constituted only 1% . . . . Moreover, a review of surveys conducted more than 60 times during the past 25 years shows that children's health care and childhood poverty have never ranked among the top 10 problems when the public was asked to identify the most important problem facing the country.<sup>170</sup>

The review also revealed that public indifference was in part based on public misperception: "Half the public (50%) believes that children are better off now than 10 years ago getting needed health care, and 55% believe that US children are more healthy than children in most other industrialized countries."<sup>171</sup> Given these misperceptions, it should not surprise us that only four percent of respondents felt strongly enough about the issue of children's health care to have written or spoken to a public official on the subject during the year prior to the survey, as compared to the seventeen percent of Americans who took similar action with respect to Medicare and Social Security.<sup>172</sup>

We know enough to have an impact on child maltreatment. What we lack is the political will to do so. Children's advocates must convince American legislators and the electorate that we can afford effective maltreatment prevention and treatment, but not our current high rate of abuse and neglect. Given the current political climate, a lengthy, uphill battle is guaranteed, and success is by no means assured.

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<sup>169</sup> See generally Alan. Monroe, *Public Opinion and Public Policy*, 62 PUB. OPINION Q. 6 (1998); Benjamin Page & Robert. Shapiro, *Effects of Public Opinion on Policy*, 77 AM. POL. SCI. REV. 175 (1983).

<sup>170</sup> Robert J. Blendon et al., *Americans' Views on Children's Health*, 280 JAMA 2122, 2123 (1998).

<sup>171</sup> *Id.* at 2123.

<sup>172</sup> *Id.* at 2127.