Child Maltreatment
in Insular & Isolated Communities

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Introduction

Ways of Seeing in the Dark: Addressing Child Maltreatment in Underserved Populations

Several years ago, two Amish girls were kidnapped from their family's farm stand by the side of the road in rural New York. The police responded and found their attempts to investigate frustrated by the realities of a family that did not trust outsiders or contemporary technology. As the Amish culture shuns photography, the family had no photos they could provide to aid in the search for their children. Law enforcement realized that they needed to work on this crime in a very different manner. They utilized a culturally respectful approach with both the parents and the larger community, first focused on gaining their trust and then bringing in sketch artists to draw likenesses of the two missing girls.

While much has been written about overrepresentation in the child welfare system, little attention has been paid to the opposite side of the equation (Fluke, Harden, Jenkins, & Ruehrdanz, 2011; Shaw, Putnam-Hornstein, Magruder, & Needell, 2008). Though there has been minimal mention of the representation of specific ethnic groups in previous research (Fluke et al., 2011; Hill, 2006; Hill, 2007; Shaw et al., 2008), the literature lacks research about cultural groups, including insular and isolated communities, who are disproportionally underrepresented in agency caseloads. This phenomenon begs a series of questions: Are some groups so isolated that they don't come to the attention of mainstream social service systems? Is there less child abuse found within some cultures? Do we possess the understanding and skills necessary to effectively engage families from insular or isolated communities?

We need to better understand why such gaps exist and how research can inform improved policies and practices. In the example of the Amish family, law enforcement took an alternative, targeted approach to engage this isolated community, focused on developing trust and engaging the family within their cultural norms—and ultimately locating the children and returning them home. The child welfare community needs to explore who is underserved and think of new ways to assist a wide range of families and communities in the protection of children.

In response to this need, CWLA and the Field Center, based at the University of Pennsylvania, partnered to issue a call for essays that address the need for more substantive research and increased awareness regarding child maltreatment in insular and isolated communities. We were, frankly, very surprised by the diversity of topics and perspectives presented in these essays. Some articles provide additional insight into topics with which we are familiar, such as those by Belanger (rural populations), Shipe (single fathers), and Whitt-Woosley and colleagues (grandparents raising children). Other articles concern specific religious sects, such as those by Palusci and colleagues (Orthodox Jews), Doig (the Lev Tahor community of Ontario, Canada), and Harder (the Amish). Authors Hom, and Mshigeni and Jenkins, discuss a group (Asian American families and children) that is well known as being underrepresented in child welfare. Davis and colleagues focus on CPS reporting in isolated indigenous communities, while Lucero and Leake explore American Indians and Alaska Natives in urban settings, both describing under-researched aspects of communities that are overrepresented in the child welfare system. And Chatfield looks at the impact on teens of the insular nature of totalistic residential treatment programs.

Some of these essays report on early research results, while others describe proposed future paths of scholarship. However, all of these contributors help to thematize the analytical value of examining groups that ostensibly operate beyond typical—or popularly stereotypical—assumptions about which youth are vulnerable and what such vulnerability

entails. These pieces not only shed light on communities that might be little known to many readers, but also help to re-assess what many well-meaning researchers might take for granted in studies of more seemingly mainstream or discursively over-represented social groups. Indeed, getting the story right about what people might dismissively call "fringe" groups like the Amish can allow scholars and practitioners to recalibrate what they see when interrogating more familiar social groups, as well.

As noted, the impact of raising awareness of the occurrence of child maltreatment in insular communities is evident across all of these essays. The contributors, however, highlight a diverse range of populations that our authors define as isolated or underserved in child welfare services, and are varied with respect to the empirical process of examining isolated experiences. These contexts open many doors as to how to translate innovative ideas into further research. For those at the beginning stages of generating new knowledge, a needs assessment might be warranted: What do leaders and helpers understand about the signs, causes, and consequences of maltreatment? How do (or should) child advocates and the community at large respond to concerns of child maltreatment? Relying upon this initial assessment, researchers might then think about innovative methodologies that will generate a theoretical basis or framework for culturally responsive healing practices to prevent and/or address the occurrence of child maltreatment. In regard to topics that are already familiar, or for those studies that have cited preliminary results, how can additional knowledge generated be used to develop or enhance healing practices? Who might need to be invited to the table to implement strategies that support insular and isolated communities to help prevent or respond to child maltreatment?

Irrespective of the knowledge already generated about this diversified topic and population, we are pleased to publish this varied group of essays and encourage further study regarding a subset of child welfare that has received too little attention to date. These essays also will serve to inform a future special issue of our *Child Welfare* journal.

References

Fluke, J., Harden, B. J., Jenkins, M., & Ruehrdanz, A. (2011). Research synthesis on child welfare: Disproportionality and disparities. *Disparities and disproportionality in child welfare: Analysis of the research,* 1.

Shaw, T. V., Putnam-Hornstein, E., Magruder, J., & Needell, B. (2008). Measuring racial disparity in child welfare. *Child Welfare, 87*(2), 23-36.

Hill, R. B. (2006). *Synthesis of research on disproportionality in child welfare: An update.* Washington, DC: Casey-CSSP Alliance for Racial Equity in the Child Welfare System.

Hill, R. B. (2007). *An analysis of racial/ethnic disproportionality and disparity at the national, state, and county levels.* Washington, DC: Casey-CSSP Alliance for Racial Equity in the Child Welfare System.

Rural Child Welfare: The Importance of Community in Human Service Deserts

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Children living in rural environments are, by definition, living in geographic areas that are set apart—i.e, in geographically insular or isolated areas. This insularity is linked to many potential challenges. With less financial wealth, less access to human capital (health care, specialists, etc.), and physical challenges (transportation, roads, access to the internet), families living in rural areas may have less access to services needed because of limited resources and geographic challenges. But research in rural child welfare is limited, unfunded, and difficult to conduct, resulting in further insularity.

Economic Capital: Rural Child Poverty

In 2015, 28% of children who were rural (non-metropolitan) and under the age of six lived in poverty—compared with 22% of children living in metropolitan areas—while 42 of the 48 counties in which more than 50% of the children live in poverty are rural counties (U.S. Department of Agriculture [USDA], 2015). Not only are children living in rural areas poorer, persistently poorer, and more deeply poor at younger ages (USDA, 2015), but rising rural child poverty results from rising income inequality. According to Hertz and Farrigan (2016), "Rising inequality explains 93 percent of the increase in rural child poverty" (Hertz & Farrigan, 2016). Children who are rural and African American or Native American are poorest, with 46.7% of children who are rural and African American living in poverty in 2015 and 40.3% of children who are rural and American Indian/Alaskan native living in poverty in that same year.

Human Capital, Physical Capital, and Access to Services

Children and families who live in rural areas have less access to human and physical capital. Allard (2007, p. 30) found that "rural poor populations living in more isolated areas or without reliable automobile transportation face nearly insurmountable spatial barriers to service providers." Because of the lack of services and social service infrastructure, "there is reason to believe that inequality in access to the safety net compounds other place-based inequalities" (Allard, 2007). Belanger and Stone (2008) found that rural counties had significantly fewer resources that child welfare practitioners identified as necessary to support families than their urban counterparts, including substance abuse treatment for children and teens, after school programs, tutoring and mentoring, school social work, intensive family preservation services, and residential treatment. Belanger, Price-Mayo, and Espinosa (2008) examined the child and family service reviews, finding consistent rural deficits in resource availability, including distances to travel for caseworker and foster/adoptive family training and for child/family visits; isolation from professional development; lack of physicians and specialty health services, particularly mental health care and trauma-informed supports; and costs associated with travel and time for travel. Americans living in rural areas have less access to health care, mental health care, and social determinants of health. According to the National Advisory Committee on Rural Health and Human Services, "a family's zip code is the new proxy for opportunity and predictor of health status in communities across the country. Where one lives determines access to resources to move up the mobility ladder, such as good schools, livable wage jobs, and reliable transportation. It also determines the degree and level of access to healthy living conditions." (NACRHHS, December 2015).

Available services are related to foster care success and adoptions from foster care. Children adopted from foster care who live in urban or suburban areas are more likely to receive training, be able to access a support group, or receive crisis counseling than their rural counterparts

(HHS, ASPE, 2011). "It is a bitterly ironic reality of the safety net that the social service programs designed to reduce the impact or prevalence of these social problems, are mismatched from communities in need" (Allard, 2007, p. 30).

Overrepresentation in Child Welfare

Possibly as a result of the many challenges faced in rural communities, and in conjunction with poverty and lower employment, children in rural areas are overrepresented in the child welfare system. According to the Fourth National Incidence Study of Child Abuse and Neglect (Sedlak, Mettenburg, Basena, Petta, McPherson, Greene, & Li, 2010), these children experience twice the rate of maltreatment for all endangerment and harm standards, except for educational neglect.

In addition, while there are varying rates of entry into foster care throughout the United States, children who lived in non-metropolitan areas that are non-adjacent to metro areas had a 33% higher rate of entry into foster care than children living in metropolitan areas (Mattingly, Wells, & Dineen, 2010). Some state analyses show even larger disproportionality of entry into foster care for rural counties. For example, Kidsdata.org provides a map showing foster care rates for the state, with children in some rural California counties entering foster care at 7 to 10 times the rate of those in urban counties (Kidsdata.org, 2017).

Siloed Human Services and Rural Insularity Resulting in Human Services Deserts

Siloed systems have long been a handicap in rural America. Federal and state "safety net" policies and funding originate at federal and state levels, resulting in diverse funding mechanisms in the most remote areas and lack of local service entirely. For example in child welfare, many states centralized intake systems are in urban centers.

Often the workforce is organized by specialization (foster care, intake, investigation, independent living), with multiple specialized workers managing several counties, resulting in human services deserts (Belanger, 2013). Other supports (Medicaid, SNAP, employment services, etc.) may require online applications—particularly problematic in the absence of reliable Internet.

The U.S. Department of Health and Human Services' Office of the Assistant Secretary for Planning and Evaluation (ASPE) noted that siloed services created implementation barriers for Rural IMPACT (Rural Integration Models for Parents and Children to Thrive) projects that target poverty with a two-generational approach to supporting families (U.S. Department of Health and Human Services, 2016). Challenges included higher costs and difficulties implementing universal intake strategies, adopting shared visions among partner agencies, federal and state policies hindering cross-systems local work, transportation problems, lack of services, and so on. Although the projects addressed intergenerational poverty, one outcome could have been entry into child welfare.

Social Capital and Community Engagement

Capital refers to the surplus/profit resulting from work relationships between owners of goods and laborers producing goods (Karl Marx, as cited in Lin, 2001). Common forms of capital include economic capital, human capital, and physical capital. Social capital refers to resources available because of membership in a social network (Bourdieu, 1991; Portes, 1998). For example, connections may lead to employment, finding housing or being accepted in college, while exclusion might result in the opposite. Coleman (1988, 1980) found that some schools and communities achieved better results through social capital instead of economics. The trust and reciprocal relationships resulting from shared values provided rich educational results, generating more social capital. Social capital has been linked with successful immigration (Portes, 1995), racial differences related to income (Loury, 1977), and rural

communities (Lyons, 2002; Onyx & Bullen, 2000; Summers & Brown, 1998). Rural communities have smaller, relatively closed systems, with intertwined relationships, reciprocity and interdependence (Coleman, 1990), with closer personal ties relating to every aspect of life (Hofferth & Iceland, 1998). Social capital is one of the strengths of many rural communities (Onyx & Bullen, 2000), resulting in greater moral cohesiveness and possibly better employment outcomes (Sherman, 2006), successful recruitment of adoptive parents in rural communities (Belanger, Copeland & Cheung, 2008), and even conservation and sustainability of resources (Belanger, 2012). In fact, understanding rural relationships and "capitalizing" on them holds promise for preventing child abuse and neglect, family preservation (Belanger, 2005), and recruitment and retention of foster and adoptive families (Belanger & Main, 2017).

Need for Research and a Rural Human Services Public Policy Framework

The Office of the Assistant Secretary for Planning and Evaluation (ASPE) of the U.S. Department of Health and Human Services (2005) noted the lack of research related to rural human services, and in particular rural child welfare. The report recommended that rural populations, areas, and systems be included in more studies; rural sites should be incorporated into program evaluations; rural sites and populations should be oversampled in order to conduct analyses and report findings; rural findings need to be reported, since many national and regional studies do include rural sites/counties/populations in studies in which rural populations are not the primary focus; studies should make better use of rural classification systems (for example more detailed continuum codes); studies should report the classification systems or definitions used; and studies could add more information to make the results more generalizable (U. S. Department of Health and Human Services, 2005). Allard (2007) also recommends a shift in data collection related to poverty research to include service availability and accessibility in

rural communities and the impact of those services on health and human service outcomes.

Family First in Rural America

In February 2018, the Family First Prevention Services Act (FFPSA) was enacted with the goal of redirecting efforts and funds to keep more children safely in their homes rather than in foster care. FFPSA also attempts to increase and improve kinship placements if removal is necessary, and ensure that children removed from their homes are placed in the least restrictive, most family-like setting. The legislation allows Title IV-E funds to be used for prevention services, particularly services for mental health treatment; substance abuse prevention and treatment; and in-home parenting training including parenting skills, parent education, and individual and family counseling. However, all services must be trauma-informed and must meet the criteria for promising, supported, and well-supported evidence-based practices. Finally, it requires these efforts to be included in the state plan and to be evaluated—and will provide technical assistance to support states and tribes with these efforts.

Because children from rural areas may be overrepresented in care; because families from rural areas have less access to the supports they need, particularly under stress; and because rural communities may not have the access or funding required to implement evidence-based programming, it is essential that specific attention be given to rural children, rural families, and rural communities in the implementation of FFPSA. There may need to be specific guidance provided in assisting families with community-based supports that may look very different from specialized supports provided in urban settings, and that may need to be tested to become evidence-based. There may need to be technical assistance provided to rural communities in the creation and implementation of parenting assistance, including skills training and parent education. There may need to be specific guidance and assistance with rural kinship providers and their communities to

determine appropriate licensing standards and to meet those standards in order to care for the families within their communities. There may need to be further testing of rural foster family recruitment methods, and technical assistance to states and tribes in rural recruitment of families. Finally, there may need to be rigorous evaluation strategies to test the implementation of FFPSA in rural communities so that rural families are not only advantaged by the legislation, but are not further disadvantaged—resulting in children removed not only from their families, but from their communities.

References

Allard, S. (2007). *Mismatches and Unmet Need: Access to Social Services in Urban and Rural America*. Ann Arbor, MI: University of Michigan National Poverty Center. Retrieved from http://www.npc.umich.edu/publications/working_papers/?publication_id=126&

Belanger, K. (2005). In search of a theory to guide rural practice: The case for social capital. In Ginsberg, L. (Ed.), *Social Work in Rural Communities*. Washington, DC: CSWE Press.

Belanger, K., Copeland, S., & Cheung, M. (2008). Faith and adoption: Reducing racial disproportionality in child welfare. *Child Welfare, 87*(2), 99–123.

Belanger, K., & Stone, W. (2008). The social service divide: Service availability and accessibility in rural vs. urban counties and impact on child welfare outcomes. *Child Welfare, 87*(4), 101–124.

Belanger, K., Price-Mayo, B., & Espinosa, D. (2008). The plight of rural child welfare: Meeting standards without services. *Journal of Public Child Welfare, 1*(4), 1–19.

Belanger, K. (2012). Sustainable Communities: Social Connectedness and Social Capital. In J. Williams & W. Forbes (Eds.), *Toward a More Livable World: Social Dimensions of Sustainability*, Nacogdoches, TX: Stephen F. Austin State University Press.

Belanger, K. (2013). Human services deserts. *Rural Monitor (Summer 2013).* Grand Forks, ND: Rural Health Information Hub. Retrieved from https://www.ruralhealthinfo.org/rural-monitor/human-services-deserts/

Belanger, K., & Main, R. (2017). *Recruitment and retention of resource families in rural and tribal communities*. Presentation retrieved from https://oercommons.s3.amazonaws.com/media/editor/92375/02_NRCDR_Retention_and_Recruitment_Presentation_Handout_Day_1_Part_1.pdf

Bolin. J., Bellamy, G., Ferdinand, A., Kash, B., & Helduser, J. (Eds.) (2015). *Rural healthy people 2020*. College Station, Texas: Texas A&M Health Science Center School of Public Health, Southwest Rural Health Research Center.

Bourdieu, P. (1991). The forms of capital. In J. G. Richardson (Ed.), *Handbook of theory and research for the sociology of education*. New York: Greenwood.

Coleman, J. (1988). Social capital in the creation of human capital. *American Journal of Sociology*, 94, 95–120.

Coleman, J. (1990). *Foundations of social theory*. Cambridge, MA: Harvard University Press.

Hertz, T., & Farrigan, T. *Understanding the Rise in Rural Child Poverty, 2003–2014*, ERR-208, U.S. Department of Agriculture, Economic Research Service, May 2016.

Hofferth, S., & Iceland, J. (1998). Social capital in rural and urban communities. *Rural Sociology, 64*(4), 574–598.

Kidsdata. (2017). *Children in foster care*. Palo Alto, CA: Lucile Packard Foundation for Children's Health. Retrieved from http://www.kidsdata.org/topic/20/fostercare/map#loct=3&fmt=2493&tf=84&center=-13325098.893387,4509031.392449&zoom=1

Mattingly, M., Wells, M., & Dineen, M. (2010). Out-of-home care by state and place: Higher placement rates for children in some remote rural places. Durham, NH: The Carsey School of Public Policy at the University of New Hampshire Scholars' Repository. Retrieved from http://scholars.unh.edu/carsey/104

National Advisory Committee on Rural Health and Human Services (NACRHHS) (December, 2015). *Child Poverty in Rural America: Policy Brief*. Rockville, MD: Author. Retrieved from https://www.hrsa.gov/advisorycommittees/rural/publications/child-poverty1215.pdf

Portes, A. (1998). Social capital: Its origins and applications in modern sociology. *Annual Review of Sociology, 24*, 1–24.

Sedlak, A.J., Mettenburg, J., Basena, M., Petta, I., McPherson, K., Greene, A., & Li, S. (2010). *Fourth National Incidence Study of Child Abuse and Neglect (NIS–4): Report to Congress, Executive Summary*. Washington, DC: U.S. Department of Health and Human Services, Administration for Children and Families. Retrieved from https://www.ers.usda.gov/topics/rural-economy-population/rural-poverty-well-being/child-poverty/

Sherman, J. (2006). Coping with Rural Poverty: Economic Survival and Moral Capital in Rural America. *Social Forces*, *85*(2), 891–913.

U.S. Department of Agriculture, Economic Research Service. (Updated July 10, 2015). *Rural poverty and well-being*. Washington, DC: Author. Retrieved from https://www.ers.usda.gov/topics/rural-economy-population/rural-poverty-well-being/

U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. (2005). *Rural research needs and data sources for selected human service topics*. Washington, DC: Author. Retrieved from https://aspe.hhs.gov/execsum/rural-research-needs-and-data-sources-selected-human-services-topics

U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. (2016). *Implementation of the federal rural Impact demonstration.* Washington, DC: Author. Retrieved from https://aspe.hhs.gov/system/files/pdf/224826/ImplementationFederalRuralIMPACT.pdf

U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. (2011). *Children adopted from foster care: Adoption agreements, adoption subsidies and other post-adoption supports*. Washington, DC: Author. Retrieved from https://aspe.hhs.gov/basic-report/children-adopted-foster-care-adoption-agreements-adoption-subsidies-and-other-post-adoption-supports

U.S. Department of Health and Human Services. (2016). Implementation of the Federal Rural IMPACT Demonstration. Retrieved from https://aspe.hhs.gov/system/files/pdf/224826/ImplementationFederalRuralIMPACT.pdf

Cultural Islands: The Subjective Experience of Treatment and Maltreatment within Insular Programs

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This is a brief, selective summary of a thesis research project titled "Adult Perspectives on Totalistic Teen Treatment: Experiences and Impact." This project was approved by the University of Florida Institutional Review Board Office (UF–IRB201701655). The summary presented here reports on findings most closely related to the topics of insularity, the potential for harm, and underrepresentation. Since the most "positive" accounts may not fall within the intersection of these topics, some participants who reported being helped or even saved by their program experience are not represented in this essay. To balance this report, the most "negative" findings have also been omitted, despite their relevance to this essay's topics. This decision is informed by a desire to counter some of the negativity bias inherent to the subject area.

The term "totalistic" is used here to describe an array of milieu features and methods associated with insular, autocratic treatment programs (De Leon, 2000) and total institutions (Goffman, 1961)

Subjectivity Statement: On a few occasions during my short career as an aspiring social scientist, I have been warned that my interest in the prevention of harm may be a threat to objective scientific inquiry. As a qualitative researcher, I appreciate the need to build credibility with readers and to design research methods that build in safeguards against unchecked biases. In this study, each decision about instrument development, recruitment, data collection, analysis, and reporting of findings was weighed with the skeptical reader in mind. The validity and usefulness of qualitative research must be assessed by each individual reader. In this brief essay, I have not provided a full review of the many choices that shaped this project. But I have done my best to take each step forward with vigilance, hoping that rigorous consistency would add depth and value to any findings.

that utilize a closed group dynamics approach (Grant & Grant, 1959) to affect global personal change. The term also implies the assumption that the totality of simultaneous, clustered conditions (Leach, 2016) are a primary "active ingredient" within intensive treatment milieus. The concept of totalistic treatment was operationalized by identifying seven key program characteristics: (1) controlled communication, (2) strict rules and punishments, (3) routine peer policing, (4) frequent group confession and/or confrontation sessions, (5) a philosophy mandating total personal change, (6) progression through required levels of treatment and (7) at least one level with all aspects of life under the control of a central authority.

The insular nature of totalistic treatment environments presents a unique paradox. The therapeutic potential of the milieu may be enhanced by eliminating outside influences but at the same time, the risk of harm may also increase proportionally as control and power are concentrated within the milieu. This essay proposes a need for qualitative research that explores and analyzes firsthand accounts of adults who have lived within such programs.

Identifying the Population and Locating the Problem

An unknown number of youth have been reeducated, rehabilitated, and reformed within a wide variety of insular treatment milieus within the United States. They lived for weeks, months, or years in boot camps, residential treatment facilities, wilderness programs, juvenile justice programs, psychiatric hospitals, group homes, faith-based treatment centers, therapeutic communities, and boarding schools. They were admitted by concerned parents, placed by foster care professionals, or adjudicated by the state to be treated for a wide variety of issues such as substance abuse, learning disabilities, developmental disorders, sexual deviance, or general delinquency and defiance. A large but unknown number have received such treatment, but very little is known about the way *maltreatment* has been experienced in these settings and perhaps

even less is known about the way totalistic programs affect adult development.

The current size of this population is also unknown. Grouphome population estimates range from 56,000 (Izzo, et al., 2016) to 212,000 (Thoburn & Ainsworth, 2015). An additional 50,000 reside within juvenile justice facilities on any given day (OJJP, 2014) and as recently as 2008, more than 200,000 youths resided in federally-funded residential treatment programs (GAO–08–346, 2008). It is difficult to estimate the number of youth residing in privately operated *state-licensed* programs, but even less is known about youth residing in *unlicensed* programs that function without oversight. In 2006, the American Bar Association estimated that 10,000 to 15,000 youths were placed in unlicensed programs each year (Behar et al., 2007).

Although there is growing consensus for the promotion of evidence-based practices (Boel-Studt & Tobia, 2016) only a handful of proven methods are currently implemented within residential care settings for youth (James et al., 2015). Within the juvenile justice system, some estimates find that only 5% to 11% of court-ordered youth receive evidence-based care (Walker, Bumbarger, & Phillippi, 2015). "Conversion therapy" and other dangerous types of behavior modification are perfectly legal in most states despite their known potential for harm (Byne, 2015; SAMHSA, 2015; Woodhouse, 2002). The number of highly totalistic treatment settings currently providing care for youth in the United States is unknown.

When methods of forceful change rely on insularity as a source of power, they may be described as "cruel and dangerous uses of thought reform techniques" (Cases of Neglect, 2007, p. 76). When these methods are experienced as repetitive traumas within inescapable settings, youth may be at risk for unique types of psychological harm (Ebert & Dyck, 2004; Herman, 1992). Some might argue that youth experiences of institutional abuse within treatment settings are scarce in the literature because this type of harm is rare. However, it is more likely that the lack of research is due to the insular nature of totalistic milieus.

Linking Insularity and Underrepresentation

The therapeutic rationale for insularity in teen treatment programs is perhaps best explained by Kurt Lewin's theory of group dynamics (Lewin, 1947; Schein, Schneier, & Barker, 1961; Schein, 1962). In this model, constant group pressure within an insulated environment is assumed to initiate a therapeutic personal change process within the individual. Although practitioners may label their methods and this process by any number of names, one of the most widely applied models based on the group dynamics approach is described by George De Leon's theory of therapeutic community (De Leon, 1995; 2000).

In this approach, problematic behaviors indicate a disorder of the whole person, requiring total transformation within an engineered social milieu capable of undermining any support for the individual's unhealthy or unwanted personal characteristics (De Leon, 1995; 2000). This requires an isolated social system that can initiate the change process by cutting ties with the outside world. By controlling the flow of information, available means of human connection, and all forms of communication, "positive" pressures can be applied more effectively. The program structure is meant to create an inescapable pressure to respond, while allowing only a narrow set of response options. In these insular treatment settings, individuals are changed by their own ability to adapt to, or survive, the demands of the milieu (Schein, 1962).

Outside influences are typically viewed as a threat because of their potential to weaken the group's power to reform an individual's personality and value structure (De Leon, 2000). Because this power is applied through group dynamics, and because newly introduced values and demands are likely to conflict with old social supports and personality structures, it is "necessary to separate the group from the larger setting" (Lewin, 1947, p. 36–37). Such isolation is crucial to this type of change process: "the effectiveness of camps or workshops in changing ideology or conduct depends in part on the possibility of creating such 'cultural islands'" (p. 37).

Underrepresentation, Awareness, and Detection

In 2008, the United States Government Accountability Office (GAO) documented numerous confirmed and reported cases of abuse and deaths within private-pay programs (GAO–08–146T, 2008; GAO–08–346, 2008; GAO–08–713T, 2008). Although the most extreme forms of abuse may be dismissed as overdramatizations (Boel-Studt & Tobia, 2016) or explained as a problem that existed primarily in the past (Reamer & Siegel, 2008), federal investigations and congressional hearings revealed widespread systematic abuse, industry-wide deceptive marketing practices, state-level administrative failures, and a need for uniform safety standards and effective oversight. Federal legislation, meant to prevent institutional child abuse by addressing these macro level factors, was proposed as early as the 1980s (Interstate Consortium, 1980) and apparently, has been introduced annually since 2008 but has yet to be enacted.

There are no federal safety standards or federal data-reporting requirements for privately funded programs, and state-level reporting requirements vary (GAO–08–346, 2008, i; H.R. 3024, 2017; Overcamp-Martini & Nutton, 2009). In addition to regulatory concerns, a persistent lack of definitional agreement on institutional forms of maltreatment creates barriers to research and prevention (Burns, Hyde, & Killet, 2013; Daly, 2014; Rabb & Rindfleisch, 1985, Penhale, 1999). Complicating this lack of regulatory and definitional boundaries, the domains of policy, practice, and research are primarily informed by the perspectives of adults who trust care providers to define for themselves what constitutes "treatment" and "maltreatment." Those on the receiving end may not be asked or may find it difficult to describe any overwhelming reactions or negative side-effects.

Whatever the program's purpose, philosophy, or licensing status, a wide range of program types have been considered together as "the black box" of residential treatment (Harder & Knorth, 2015; Palareti & Berti, 2009). They are characterized by their closed doors and our inability

to make meaningful generalizations about what goes on behind them. These settings can be characterized by how insular, restrictive, and intrusive they are, but rather than thinking in dichotomous terms, it may be more important to conceptualize their features on a continuum of "*how* totalistic" they may be. Total institutions for adults have been characterized by a range of controls on personal autonomy and communication with the outside world (Goffman, 1961). For youth, the ability to communicate freely with family and friends in the outside world is often limited or impossible, and censored or controlled forms of communication are often contingent upon compliance with harsh demands. In these environments some may be unable or afraid to report abuse because of the threat of further restrictions and punishment (Behar et al., 2007).

The Need for Qualitative Research

Only a handful of qualitative studies examine youth perspectives on highly restrictive environments (Chama & Ramirez, 2014; MacLeod, 1999; Polvere, 2011; Rauktis, 2016; Rauktis, Fusco, Cahalane, Bennet, & Reinhart, 2011). In these studies, a range of totalistic program features are described with varying degrees of detail. Additional examples of firsthand accounts within highly restrictive environments describe adult treatment settings (Frankel, 1989; Gowan & Whetstone, 2012; Hood, 2011; Skoll, 1992). There is a lack of research examining the firsthand accounts of adults who, as adolescents, spent weeks, months, or years of their lives inside a highly totalistic treatment program. This type of research might help to explain some of the features that characterize potentially harmful program types (Farmer, et al., 2017). Additionally, the discourse on evidence-based practices would benefit from a wider range of evidence that considers the impact of totalistic program methods.

Current ethics of care assume that treatment providers will rely on the least restrictive and least intrusive methods (Simonsen, Sugai, Freeman, Kern, & Hampton, 2014; Weithorn, 2005). Although this

standard is widely known, its meaning is fuzzy and questionable because current perspectives and measures of restrictiveness and intrusiveness are typically framed by adults rather than their youth targets (Polvere, 2011; Rauktis, et al., 2011). Qualitative research may help shine a light behind closed doors and illuminate the subjective experiences of this underrepresented and often stigmatized population.

To explore the subjective experiences reported by adults who lived within totalistic teen treatment environments, this study was designed to answer three research questions: How are totalistic teen treatment methods experienced? How do participants describe the immediate effects of the program? And how do they describe the long-term impact of the program?

Methods

In the first stage of this project, 223 individual responses to an online questionnaire were collected for quantitative analysis and to identify potential interview participants. Seventy-four program facilities were represented in the original sample of 223 participants, and 71 of these programs were rated as highly totalistic. Sixty-six percent of respondents identified as female and 89% as White. The second stage of the study began with the creation of a sampling frame of respondents who rated their program as highly totalistic. Seven program characteristics were measured on a 5-point scale and participants with a mean index score below 4.00 were screened-out to ensure that qualitative data would be collected only from those who had experienced a "highly totalistic" teen treatment program. A total of 190 adults with a mean score of 4.00 to 5.00 were identified as the interview sampling frame. Electronically recorded qualitative data were collected during one-hour phone interviews with 30 participants selected from the frame. Each interview followed the same basic protocol, but participants were encouraged to speak to what was most important to them. All interviews were fully transcribed and coded line by line for categorical, comparative, and thematic analyses.

Findings

Participants described four types of programs: therapeutic boarding school; residential treatment; wilderness/outdoor; and intensive out-patient. The majority described censored written communications to and from parents and brief, infrequent, closely monitored phone calls. Communication with parents was frequently described as a privilege earned through obedience that could be taken away for rule violations. All participants reported that the *content* of communications was also closely monitored and for many, communication with parents could be restricted if they were caught complaining about the program. Perhaps more profoundly, some mentioned that complaints about the program might be taken as an indication that one's personal mental health was failing, and staff could present this to parents as evidence that their children were "not ready" to communicate with the outside world and needed to focus more intensely on themselves.

> I remember being like, "why am I in a place where I can't be in contact with the outside world? Why do I not get to be allowed to look out the windows? Why am I not allowed to know the news? Why can't I, like, contact any of my friends or family?" Just feeling really trapped and not really having any way to express that because, like, you couldn't express that to the staff without consequence, you would be punished for it and get consequences, negative talk of the program was met with a consequence.

The content and amount of communication between residents was also strictly controlled and enforced by threat of punishment, loss of privileges, and additional time spent on lower levels of the program. Books, magazines, movies, music, television, and Internet access were restricted, redacted or completely forbidden. Some described formal program structures that forbade "fluff talk"—superficial topics of conversation not directly pertaining to one's personal problems.

A range of different types of isolation punishments were described by several participants, some involving multiple days spent in tiny rooms.

More than one participant described an isolation practice where youth who had "maxed out" their time in formal isolation could be forced to sit in isolation at their desks or in the corner of a room, made to stare at a wall all day long for months on end.

> The longest I experienced it was two weeks, but someone who had attended 10 years after me told me they were there for a month, which is mind-boggling. I don't know how you could do that without causing psychological damage, it's just an isolation chamber with people constantly being around you.

More common forms of isolation punishments were called "blackouts," "bans," or being put on "ghost challenge." The name of the practice differed across multiple programs but in all such cases, youth were forbidden to speak or interact with others while moving through the day's schedule.

> We weren't able to look out the window, free communication with other students wasn't really a thing, it was very, very strict, so just a lot of forced silence. And then a lot of, I think they would call them special processes or special challenges that other girls would be placed on, as far as, they would be on a ghost challenge, so no one was allowed to look at them or talk to them for a certain period of time.

These modified seclusion practices could be imposed for many weeks or months, and the impact of such practices extended to those witnessing them. Participants described emotional distress and anxiety because they were unable to intervene, or were punished for attempting to intervene, while other youth were subjected to severe punishments, injustices, or medical neglect. They described an autocratic authority structure where any attempt to defend a peer against staff decisions would result in severe consequences.

They describe an environment totally insulated against outside influences but also designed to prevent any sense of privacy or personal autonomy. These deprivations were typically experienced with a

sense of powerlessness and an inability to find relief from the relentless pressure of "being poked at" and confronted. Group humiliation rituals were frequently reported to occur in the context of therapy and many described the program's effect as a process of being torn down and built back up.

> Every single aspect of who you are and what has ever happened to you and what you know is shattered and taken away and you're told you're wrong and you don't trust your memory and you have to completely rebuild your personality, your interests, your favorite color, like all this stuff, before you're allowed to leave.

For many, the process of readjusting to life outside the program was also traumatic. A large number reported feeling unprepared for life in the "real world." Many were unable to mend friendships that had been disrupted by their sudden absence and inability to communicate. A theme of shattered trust, especially for those who experienced emotional trauma, was exacerbated by barriers to free communication. Many described a long-term struggle to explain their experiences to parents and frustration over not being believed when they described them. Others mentioned current uncertainty about how much their parents knew or didn't know about daily life in the program. For some, the process of coming to terms with the experience of trauma was impaired by self-blame and internalized program philosophies: "basically that we're responsible for everything that happens to us and you know if something negative happens then there was something you did that you need to be accountable for." Others mentioned feeling afraid to complain about the program after reentry because their parents were instructed to consider placing them in treatment again if they began speaking negatively of the program.

When participants were asked about the way their perspective had changed over the years, many said they spoke more glowingly about their experiences in the first years after graduation or release. Progress through, and graduation from, the program was contingent on having a positive opinion about the experience. Several described a long process

of denial, disillusionment, and acceptance, taking many years for some of them to become comfortable "swallowing" not just the way they were treated but the way they treated others when participating in group confrontations.

> The best way to avoid a heavy confrontation was to confront other people about things that you saw them do. When I think about some of the things that I personally confronted people about in group, a lot of them, it's probably the meanest I've ever been to anybody.

Most interviewees wanted to participate in this study to help raise awareness and prevent harm. They want parents and guardians to know what goes on in such programs and "that these places exist."

Relevance to Practice

Participants in this study reveal much about the way orchestrated group dynamics can become "self-sealing systems," as described by Janja Lalich in *Bounded Choice: True Believers and Charismatic Cults* (2004). In cultic dynamics, Lalich describes how systems of domination and affiliation within insular groups can facilitate internalization of orga-nizational values. She describes how this process strengthens loyalty to the group, intensifies emotional bonds between members, and may lead to personal closure that insulates participants against outside sources of information and creates distance from one's own pre-group identities.

In the research summarized here, almost all participants reported that some of their strongest memories stem from close bonds they formed with peers in the program. Many noted this as a paradox and a few used the term "double-edged sword" to describe the effects of intense social dynamics within a closed environment. The majority of those who attributed positive effects and outcomes to their program experiences emphasized that such benefits were in addition to a range of negative effects and long-term harm. This complex mix was described by many as a range of paradoxical extremes that includes connection

and growth as well as "brainwashing" and memories of "brutal" conditions. During several interviews, participants interrupted themselves to apologize for "sounding so negative," or to explain why it was so complicated. Several noted that for many years, the struggle to explain their experiences had been a continual cause of stress and alienation.

Practitioners may describe residential treatment according to the way they imagine their methods to work. However, there is a difference between the way methods are conceptualized by adults and the way they are experienced by youth. This unresolved dichotomy contributes to the potential for psychological harm in residential treatment settings (Zimmerman, 2004). The potential for such iatrogenic effects can be obscured by the recurrent use of words and phrases that enhance institutional power while invalidating the subjective experience of harm (Thomas, 1982). When professionals dismiss charges of institutional maltreatment as a youth's attempt to manipulate adults, reports of abuse may be reduced to a symptom of pathology and assumed to indicate need for even more intensive treatment.

While it is important to predict the effectiveness and beneficial impacts of any intervention, it is equally important to be able to identify and prevent negative side-effects and harm. To predict unwanted outcomes, such outcomes must first be understood from the standpoint of the individuals who have direct knowledge about them. Only then can the discourse on persuasion, thought reform, treatment and maltreatment move beyond polemic reactions (Zablocki, 1997) and simplistic dominant narratives (Polvere, 2011) that may ignore unintended and harmful side-effects of insular programming within totalistic settings. This type of prevention science would require theoretical knowledge and the capacity for prediction through "dark logic" models (Bonell, Jamal, Melendez-Torres & Cummins, 2014) that would approach institutional abuse as a "wicked problem" (Burns, Hyde, & Killet, 2013). These models would need to be developed and informed by a wide range of data, including rigorous, systematic analyses of firsthand accounts and subjective experiences (Smith, 2010).

Conclusion

This summary describes one of few studies to examine totalistic treatment as a characteristic set of restrictive and intrusive practices applied simultaneously within insular environments. The 30 participants interviewed in this study lived for an average of 20 months within a highly totalistic teen treatment program. They explained their subjective experiences of life within one facility location and a total of 25 different programs were described at length. These treatment settings can be characterized by the same set of interwoven totalistic features that should be considered together as simultaneous factors characterizing the milieu structure and program type.

Several participants interviewed in this study were released from such a milieu only within the last few years, but their collective experiences span across four decades, with intake dates from 1982 to 2016. The findings indicate that some youth living within highly insular environments have experienced aspects of totalistic teen treatment as institutional abuse. An unknown number of Americans have lived for months and years within the high-pressure vacuum of a "cultural island," and when they are asked to shine a light behind closed doors, they describe a range of institutional practices that warrant further investigation, research, and prevention.

References

Behar, L., Friedman, R., Pinto, A., Katz-Leavy, J., & Jones, H. W. G. (2007). Protecting youth placed in unlicensed, unregulated residential "treatment" facilities. *Family Court Review, 45*(3), 399-413. doi:10.1111/j.1744-1617.2007.00155.x

Boel-Studt, S. M., & Tobia, L. (2016). A review of trends, research, and recommendations for strengthening the evidence-base and quality of residential group care. *Residential Treatment for Children & Youth, 33*(1), 13. doi:10.1080/0886571X.2016.1175995

Bonell, C., Jamal, F., Melendez-Torres, G. J., & Cummins, S. (2015). 'Dark logic': Theorising the harmful consequences of public health interventions. *Journal of Epidemiology and Community Health, 69*(1), 95–98. doi:10.1136/jech-2014-204671

Burns, D., Hyde, P., & Killett, A. (2013). Wicked problems or wicked people? reconceptualising institutional abuse. *Sociology of Health & Illness, 35*(4), 514–528. doi:10.1111/j.1467-9566.2012.01511.x

Byne, W. (2016). Regulations restrict practice of conversion therapy. *LGBT Health, 3*(2), 97–99. doi:10.1089/lgbt.2016.0015

Cases of child neglect and abuse at private residential treatment facilities: Hearing before the committee on education and labor: House of Representatives, 110th Cong. (2007). Retrieved from: https://www.gpo.gov/fdsys/pkg/CHRG-110hhrg38055/pdf/CHRG-110hhrg38055.pdf

Chama, S., & Ramirez, O. (2014). Young people's perceptions of a group home's efficacy: A retrospective study. *Residential Treatment for Children & Youth, 31*(2), 120-134. doi:10.1080/0886571X.2014.918442

Daly, K. (2014). Conceptualising responses to institutional abuse of children. *Current Issues in Criminal Justice, 26*(1), 5–29.

De Leon, G. (1995). Therapeutic communities for addictions: A theoretical framework. *International Journal of Addictions, 30*(12), 1603–1645. doi:10.3109/10826089509104418

De Leon, G. (2000). *Therapeutic community: Theory, model, and method*. New York: Springer Publishing Company.

Ebert, A., & Dyck, M. J. (2004). The experience of mental death: The core feature of complex posttraumatic stress disorder. *Clinical Psychology Review, 24*(6), 617–635. doi:10.1016/j.cpr.2004.06.002

Farmer, E. M. Z., Murray, M. L., Ballentine, K., Rauktis, M. E., & Burns, B. J. (2017). Would we know it if we saw it? assessing quality of care in group homes for youth. *Journal of Emotional and Behavioral Disorders, 25*(1), 28–36. doi:10.1177/1063426616687363

Frankel, B. (1989). *Transforming identities: Context, power and ideology in a therapeutic community*. New York: Peter Lang.

GAO-08-346, House of Representatives, Report. (2008). Retrieved from: https://www.gao.gov/new.items/d08346.pdf

GAO-08-146T: Residential treatment programs: Concerns regarding abuse and deaths in certain programs for troubled youth: United states government accountability office testimony before the committee on labor and education: House of Representatives, (2008). Retrieved from: https://www.gao.gov/new.items/d08146t.pdf

GAO-08-713T: Residential programs: Selected cases of death, abuse, and deceptive marketing: United states government accountability office testimony before the committee on education and labor. House of Representatives, (2008). Retrieved from: https://www.gao.gov/new.items/d08713t.pdf

Goffman, E. (1961). *Asylums*. New York, NY: Anchor Books.

Gowan, T., & Whetstone, S. (2012). Making the criminal addict: Subjectivity and social control in a strong-arm rehab. *Punishment & Society, 14*(1), 69–93. 10.1177/1462474511424684

Grant, J. D., & Grant, M. Q. (1959). A group dynamics approach to the treatment of nonconformists in the navy. *The Annals of the American Academy of Political and Social Science, 322*(1), 126–135. doi:10.1177/000271625932200116

Harder, A. T., & Knorth, E. J. (2015). Uncovering what is inside the 'black box' of effective therapeutic residential youth care. In Whittaker, J. K., del Valle, J. F. & Holmes, L. (Ed.), *Therapeutic residential care for children and youth: Developing evidence-based international practice* (pp. 217–230). London & Philadelphia: Jessica Kingsley Publishers.

Herman, J. L. (1992). Complex PTSD: A syndrome in survivors of prolonged and repeated trauma. *Journal of Traumatic Stress, 5*(3), 377–391. doi:10.1002/jts.2490050305

Hood, D. E. (1992). *Addiction treatment: Comparing religion and science*. New Brunswick: Transaction Publishers.

H. R. 3024, Stop child abuse in residential programs for teens act of 2017. 115th cong. (2017). Retrieved from: https://www.congress.gov/115/bills/hr3024/BILLS-115hr3024ih.pdf

Interstate Consortium on Residential Child Care. (1980). *Residential child care guidebook*. Trenton, NJ: The Interstate Consortium, Department of Human Services.

Izzo, C. V., Smith, E. G., Holden, M. J., Norton, C. I., Nunno, M. A., & Sellers, D. E. (2016). Intervening at the setting level to prevent behavioral incidents in residential child care: Efficacy of the CARE program model. *Prevention Science, 17*(5), 554–564. doi:10.1007/s11121-016-0649-0

James, S., Thompson, R., Sternberg, N., Schnur, E., Ross, J., Butler, L., . . . Muirhead, J. (2015). Attitudes, perceptions, and utilization of evidence-based practices in residential care. *Residential Treatment for Children & Youth, 32*(2), 144–166. doi:10.1080/0886571X.2015.1046275

Lalich., J. (2004). *Bounded choice: True believers and charasmatic cults*. Los Angeles: University of California Press.

Leach, J. (2016). Psychological factors in exceptional, extreme and torturous environments. *Extreme Physiology & Medicine, 5*(1), 7. doi:10.1186/s13728-016-0048-y

Lewin, K. (1947). Frontiers in group dynamics: Concept, method and reality in social science; social equilibria and social change. *Human Relations, 1*(1), 5–41.

MacLeod, M. (1999). The abuse of children in institutional settings: Children's perspectives. In N. Stanley, J. Manthorpe & B. Penhale (Eds.), *Institutional abuse: Perspectives across the life course* (pp. 44–65). New York: Routledge.

Office of Juvenile Justice Programs (OJJP). (2014). *Coming into focus: The future of juvenile justice reform.* Washington, D.C.: Office of Juvenile Justice and Delinquency Prevention. Retrieved from: https://www.ojjdp.gov/pubs/248957.pdf

Overcamp-Martini, M., & Nutton, J. (2009). CAPTA and the residential placement: A survey of state policy and practice. *Child & Youth Care Forum, 38*(2), 55–68. 10.1007/s10566-009-9067-9

Penhale, B. (1999). Introduction. In Stanley, N., Manthorpe, J. & Penhale, B. (Eds.), *Institutional abuse: Perspectives across the life course* (pp. 1–15). London & New York: Routledge.

Polvere, L. (2011). Youth perspectives on restrictive mental health placement: Unearthing a counter narrative. *Journal of Adolescent Research, 26*(3), 318–343. doi:10.1177/0743558410391257

Palareti, L., & Berti, C. (2009). Different ecological perspectives for evaluating residential care outcomes: Which window for the black box? *Children and Youth Services Review, 31*(10), 1080-1085. doi:10.1016/j.childyouth.2009.07.011

Rabb, J., & Rindfleisch, N. (1985). A study to define and assess severity of institutional abuse/neglect. *Child Abuse & Neglect, 9*(2), 285–294. 10.1016/0145-2134(85)90021-3

Rauktis, M. E., Fusco, R. A., Cahalane, H., Bennett, I. K., & Reinhart, S. M. (2011). "Try to make it seem like we're regular kids": Youth perceptions of restrictiveness in out-of-home care. *Children and Youth Services Review, 33*(7), 1224–1233. doi:10.1016/j.childyouth.2011.02.012

Rauktis, M. (2016). "When you first get there, you wear red": Youth perceptions of point and level systems in group home care. *Child and Adolescent Social Work Journal, 33*(1), 91–102. doi:10.1007/s10560-015-0406-4

Reamer, F. G., & Siegel, D. H. (2008). *Teens in crisis: How the industry serving struggling teens helps and hurts our kids.* New York: Columbia University Press.

Schein, E. H., Barker, C. H., & Schneier, I. (1961). *Coercive persuasion: A socio-psychological analysis of the "brainwashing" of american civilian prisoners by the chinese communists.* New York: Norton.

Schein, E. (1962). Man against man: Brainwashing. *Corrective Psychiatry and Journal of Social Therapy, 8*(1–4), 90–97.

Simonsen, B., Sugai, G. M., Freeman, J., Kern, L., & Hampton, J. (2014). Ethical and professional guidelines for use of crisis procedures. *Education and Treatment of Children, 37*(2), 307–322. 10.1353/etc.2014.0019

Skoll, G. R. (1992). *Walk the walk and talk the talk: An ethnography of a drug abuse treatment facility.* Philadelphia: Temple University Press.

Smith, M. (2010). Victim narratives of historical abuse in residential child care. *Qualitative Social Work, 9*(3), 303–320. doi:10.1177/1473325010367816

Substance abuse and mental health services administration (SAMHSA). (2016). Ending conversion therapy: Supporting and affirming LGBTQ youth. Retrieved from: https://store.samhsa.gov/shin/content/SMA15-4928/SMA15-4928.pdf

Thoburn, J., & Ainsworth, F. (2015). Making sense of differential cross-national placement rates for therapeutic residential care. In J. K. Whittaker, J. F. del Valle & L. Holmes (Eds.), *Therapeutic residential care for children and youth: Developing evidence-based international practice* (pp. 37–46). Philadelphia: Jessica Kingsley Publishers.

Thomas, G. (1982). The responsibility of residential placements for children's rights to development. *Child and Youth Services, 4*(1–2), 23–45. doi:10.1300/J024v04n01_05

Walker, S. C., Bumbarger, B. K., & Phillippi, S. W. (2015). Achieving successful evidence-based practice implementation in juvenile justice: The importance of diagnostic and evaluative capacity. *Evaluation and Program Planning, 52*, 189–197. doi:10.1016/j.evalprogplan.2015.05.001

Weithorn, L. A. (2005). Envisioning second-order change in america's responses to troubled and troublesome youth. *Hofstra Law Review, 33*(4), 1305.

Woodhouse, B. B. (2002). Speaking truth to power: Challenging "the power of parents to control the education of their own". *Cornell Journal of Law and Public Policy, 11*(3), 481.

Zablocki, B. (1997). The blacklisting of a concept: The strange history of the brainwashing conjecture in the sociology of religion. *Nova Religio: The Journal of Alternative and Emergent Religions, 1*(1), 96–121. doi:10.1525/nr.1997.1.1.96

Zimmerman, D. P. (2004). Psychotherapy in residential treatment: Historical development and critical issues. *Child and Adolescent Psychiatric Clinics of North America, 13*(2), 347–361. doi:10.1016/S1056-4993(03)00122-6

Do 'Overrepresented Groups' Get Too Much CPS Attention or Not Enough?: Child Maltreatment Reporting of Indigenous Populations in Isolated Communities

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Overrepresentation of indigenous populations in child welfare is pervasive throughout the world. Indigenous groups, who often live in geographically isolated or rural locations, have significantly higher incidences of reports made to child protective services (CPS) than does the general population, which can lead to more substantiations, court involvement, and foster care entry (Auditor General of Canada, 2011). Many factors contribute to overrepresentation of indigenous families in CPS, including systemic racism, oppression, and institutional bias.

However, actual child protection concerns—meaning actions or inactions by caregivers that merit the label of "child maltreatment"—may in fact be underreported in indigenous groups, despite the fact that these groups are overrepresented in the system. For example,lack of infrastructure or effective reporting systems may preclude some members of indigenous groups from reporting actual child maltreatment.

CPS reporting in indigenous communities is an important area for exploration, given that time and effort spent investigating such reports directs valuable child welfare agency resources toward concerns that may not constitute genuine maltreatment. Perhaps more concerning, screening such reports for investigation may perpetuate systemic bias and oppression while opening up individual families to the negative outcomes associated with CPS involvement.

Factors Influencing CPS Reporting in Isolated Indigenous Communities

Research in Canada suggests that disproportionality and disparity increases throughout the life of a child protection case (National Collaborating Centre for Aboriginal Health, 2013). Consequently, individuals who report families to CPS have a significant influence on a family's path, as does the effectiveness of the system designed to capture CPS reports from those people.

In some indigenous communities, reports to CPS agencies frequently come from mandated reporters, including school personnel, health professionals, and law enforcement. Mandated reporters often may not be members of the indigenous communities, which could influence knowledge of cultural norms, potentially introduce unconscious bias, and add to institutional bias. CPS system barriers, including inadequate worker training and language conflicts, could contribute to questionable reports.

Members of indigenous communities may not report child maltreatment concerns due to these factors. Additionally, generational mistrust of CPS may mean that community members do not want to contact CPS for fear of what CPS intervention may mean for a family. And in some isolated indigenous communities, a lack of formal reporting mechanisms may inhibit reports from being made by members of the community rather than mandated reporters.

Based on these factors, we suggest research examining three questions:

1. Are authentic child maltreatment concerns reported equally among different populations?
2. Are there systemic and cultural factors that inhibit members of isolated indigenous communities from reporting protection concerns?
3. How accurately does the CPS system identify and serve true protection concerns for reports from isolated indigenous communities?

Answers to these research questions could support a better understanding of the complexities, processes, and potential barriers of the reporting systems for indigenous communities. This knowledge could inform what is known about child maltreatment and reporting patterns of maltreatment among indigenous populations. Ultimately, these efforts could contribute to decreasing disproportionality and increasing CPS ability to respond to genuine concerns.

Theoretical Framework

"Social constructionism" is a sociological approach that examines how experiences shape the ways individuals operate in the world, including how they interact with other people (McKinley, 2015). Both those who work in the child protection system and those who are served by the system have had experiences that influence how they view the world, which may affect how they relate to one another. Social constructionism provides a useful lens through which to look at both the effectiveness of the child protection system in identifying child protection concerns and the barriers in the community to accurately reporting these concerns.

Reporting Child Maltreatment in Insular or Isolated Communities

There are several stages in the reporting process, each of which contains potential barriers to effective reporting.

- The potential reporter first decides whether he/she believes a child protection concern exists, based on knowledge, beliefs, and cultural norms that vary from person to person.
- The decision to report depends on a person's knowledge and level of trust in the system, the reporter's concerns about community reaction, and the decision's implications for the reporter (who may have a personal relationship with the subject of the report).
- Reporting may be difficult due to barriers like lack of access to a CPS office or a phone with which to call CPS.

Reporting Systems

CPS agencies that serve isolated or insular communities must have a system for receiving reports. Several variables influence the effectiveness of the reporting system:

- Is there a local and accessible office where reports can be made?
- Does the community trust the staff in the local office?
- If there is no local office, are other reporting methods available, and are they easy to access?

Another variable is the skill level of the CPS workers assigned to receive reports:

- Do they understand the culture of the community(ies) they serve?
- Do they have any beliefs that influence their decision-making about the community(ies) they serve?
- Are they trained in effective interviewing?
- Is there a quality assurance system in place to ensure the quality of reports and decision-making?

Community Factors

Factors specific to the communities in which indigenous populations live could cause underrepresentation of actual CPS concerns. These include historical, geographical, language, cultural, and other factors:

- Historical events, such as the forcible removal of indigenous children from their families in some areas, have damaged generations of indigenous families. This has created a strong distrust of the CPS system, which could negatively affect willingness to report.
- Language barriers may exist between the reporter and the worker taking the report.
- Definitions of child maltreatment may vary between the community and the agency, due to factors such as divergent values regarding child autonomy or different beliefs around developmental milestones.
- Roles within a community, including elder and gender roles, may affect who makes decisions, who determines what is a concern, and whether to involve the child protection system.

Methods

To understand the reasons indigenous populations in isolated communities are becoming involved in CPS, a robust needs assessment could be conducted using a mixed-methods approach.

- *Analysis of secondary data*. Use existing surveys to get a baseline understanding of existing groups (e.g., NDACAN, AFCARS).
- *Meta-analysis.* Conduct an analysis of similar scientific studies to understand what is known.
- *Administrative data.* Examine administrative data to understand the existing reporting system. This would include examining who has reported child protection concerns, what concerns are being reported, and what are the investigation outcomes.

- *Case reviews.* Read a sample of cases to gather baseline data on current practice as well as review current policies and procedures.
- *Interviews.* Interview staff at all levels, community members, and potential reporters.
    - Conduct interviews in several remote communities to understand the culture of each community, any barriers to reporting (including cultural and systemic ones), and the community's knowledge of child maltreatment.
    - Conduct interviews of mandated reporters who work with remote communities to understand their levels of knowledge about child maltreatment and their views on the communities they serve.
    - Conduct interviews to gauge the visibility of children in the community. This would include developing an understanding of who has eyes on the children, the degree to which they are seen in the community, and the extent to which they are involved in community activities.

Conclusion

Systems should examine not only who is being reported, but also *what* is being reported. While the populations we describe here would traditionally fall into the "overrepresented" category, it is important to examine whether true child protection concerns are reaching the system in such a way that the system can intervene appropriately. It is also important to examine whether the current system is accurately capturing child protection concerns that are valid. To be clear, we are not advocating for increased reporting on overrepresented populations. In fact, we believe this type of research and approach will address the disproportionality of overrepresented populations as part of the process of more accurately capturing the concerns that child protection agencies (as opposed to other parts of the system) should be tasked with managing.

Unless we spend time examining the communities we serve, our relationships with those communities, the systemic barriers that make our systems ineffective, and the effectiveness of the workers and supervisors who hold power over decisions and outcomes, we will continue to see ineffective systems that spend time and money addressing the wrong issues and involving the wrong people. This could potentially affect the levels of both overrepresentation and underrepresentation in the system.

References

Auditor General of Canada. (2011). Programs for First Nations on reserves. In *2011 June Status Report of the Auditor General of Canada*. Ottawa, ON: Author. Retrieved from http://www.oag-bvg.gc.ca/internet/English/parl_oag_201106_04_e_35372.html

McKinley, J. (2015). Critical argument and writer identity: Social constructivism as a theoretical framework for EFL academic writing. *Critical Inquiry in Language Studies, 12*(3), 184–207. doi:10.1080/15427587.2015.1060558

National Collaborating Centre for Aboriginal Health. (2013). First Nations and non-Aboriginal children in child protection services. Prince George, BC: Author. Retrieved from https://www.nccah-ccnsa.ca/495/First_Nations_and_non-Aboriginal_children_in_child_protection_services.nccah?id=7

Lev Tahor: Child Maltreatment in an Insular Community

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When the Lev Tahor community of approximately 200 persons arrived overnight in the Ontario Municipality of Chatham-Kent, Chatham-Kent Children's Services, an amalgamated child welfare and children's mental health agency, was faced with potential child welfare investigations and provision of support services to a unique and extremely insular religious "sect." Chatham-Kent is a predominantly rural community with a relatively homogeneous White, Christian population—with the exception of a small Indigenous First Nation. The agency created a separate, specialized child protection team to interact with the Lev Tahor, hypothesizing that this smaller team could quickly become familiar with the religious beliefs and practices of this group, ensure consistent personnel and service delivery, and develop an awareness of dynamics within the individual families and the group as a whole.

Lev Tahor (Pure Heart), a Jewish religious community, was founded in the 1990s by Rabbi Shlomo Helbrans, an Israeli citizen. Although originally established in Israel, Rabbi Helbrans moved his community to the United States after ongoing conflict with the Israeli government. While in the United States, Helbrans was convicted of kidnapping in 1994 and served a two-year prison term before being deported to Israel in 2000. Shortly after his deportation, he was granted entry into Canada and refugee status due to allegations of religious and political persecution that, he said, would threaten him if he returned to Israel (Fogelman, 2015a; 2015b).[1]

Lev Tahor followers are ultra-orthodox, Hassidic Jews who believe in the strict adherence to the Torah, reject "modern" lifestyles, follow a strict kosher diet, and predominantly speak Yiddish. Males are always in positions of authority; women dress in traditional black clothing, similar to the Muslim abaya and hijab; young females are educated in household and childcare skills; boys are educated in the teachings of the Torah. The children do not attend mainstream school. The families tend to have multiple children. Most of the members of the sect are very computer- and social media-literate.

In 2003, the Lev Tahor community settled and expanded in Sainte Agathe-des Monts, Quebec, and from 2007 to 2013, the child protection agency in Quebec became increasingly concerned about the safety and well-being of many of the group's children. Neglect concerns escalated briefly in 2011 around the apparent lack of proper education for the children. By 2013, investigations of underage marriages, child neglect, inappropriate use of non-prescribed drugs to control behavior, social isolation, limited education for the children, and removal of children from their parental homes for non-compliance with community norms resulted in provisional court applications for three families involving 14 children. On November 18, 2013, approximately 54 adults and 150 children left Quebec on several buses in the middle of the night and arrived in Chatham-Kent, Ontario. As a result of this flight, the Quebec court ordered the 14 children into foster care to facilitate an assessment process. In addition, Quebec obtained approximately 90 "authorizations to locate and deliver" with respect to the Lev Tahor children in the community. These orders authorized any police officer to locate and deliver the children named in the orders into the care of the province of Quebec (Comission des Droits de la Personne et des Droits de le Jeunesse, 2015).[2]

The Municipality of Chatham-Kent is one of the larger geopolitical areas in Southwestern Ontario. It is predominantly a rural community with a total population of about 105,000, relying on an economic base of agriculture and related automotive industries. The municipality has a small Delaware Nation indigenous community that accounts for roughly 3% of the population.

In order to ensure a consistent, effective response to the possibility of multiple child protection investigations concerning this sect, Chatham-Kent Children's Services (CKCS) dedicated a team of experienced child protection workers to become involved in all interactions with the Lev Tahor community. We also met with the Lev Tahor leaders on numerous occasions in the spirit of open communication. Although the leaders were initially receptive, it became obvious that they were not cooperative—and, in fact, quickly opted to utilize social media and their dedicated website in an attempt to sway public opinion and discredit CKCS. Due to the large number of children involved, CKCS convened an immediate community planning and collateral partnership meeting to update those social service agencies most likely to be contacted by, or provide support services to, Lev Tahor members.

Due to the sheer number of families involved, the ever-changing circumstances with Lev Tahor leaders and community members, and reports from Quebec and Israel, the importance of daily, regular communication among the specialized service team was critical. Combined with the need for effective communication was the recognition of the stress level on all aspects of the organization and the acknowledgement of the importance of staff wellness. Expertise and experience with media and public relations became an immediate need for CKCS due to Lev Tahor's astute use of social and regular media, which focused on their allegations of racial and religious discrimination. A dedicated media person allowed CKCS to fully and openly respond to reports, inaccuracies, and general inquiries from all media sources.

On December 4, 2013, CKCS requested in the Ontario courts for warrants of removal for the 14 children based on the Quebec request and accompanying documents. That request was denied. The three families with 14 children fled Canada, bound for Guatemala; however, two families with six of these children were detained in Trinidad and Tobago and returned to Canada, whereupon the children came into protective care of the agency (Ontario Superior Court of Justice, Chatham-Kent Children's Services v. JS, 2014). The other family and six children successfully entered Guatemala. Chatham-Kent Children's

Services had no alternate placement options for the Lev Tahor children that would effectively meet their cultural, religious, and ethnic needs. Although a Jewish agency in Montreal offered readily available foster homes, there was general consensus that the children should remain in Ontario, closer to their community. Jewish Family and Child (JF&C) in Toronto had provided some religious and cultural information and support to the CKCS staff during the investigation and assessment of the Lev Tahor families, and offered to assist with exploring placement options for these children.

Throughout the months of May and June 2014, CKCS received numerous allegations about the health and safety of the Lev Tahor children in Guatemala, who were technically the subjects of a court order and were to be brought into care upon their return to Canada. Initial inquiries regarding interventions through the Child Abduction Convention of The Hague Convention revealed that this convention did not apply between Canada and Guatemala due to a lack of signatories, and therefore could not be used for the return of the children (Convention of 25 October 1980 on the Civil Aspects of International Child Abduction, 1980). CKCS and JF&C made a joint submission to Canadian Foreign Affairs requesting their assistance, which did result in some intervention by way of an assessment in Guatemala, but no definitive findings or concerns were forthcoming. International Social Services were also contacted and had no additional suggestions on returning the children to Canada. By mid-June 2014, all of the Lev Tahor community, with the exception of the families subject to the court order, had surreptitiously left Chatham-Kent and apparently had settled in Guatemala (Surkes, 2016).

Although these lessons learned are from a Canadian perspective, many of them are applicable to working with other insular or isolated communities throughout North America.

1. The intervention and assessment with a "closed community" challenged the agency with respect to honoring community mores of education, child rearing, and rights to individual and religious

freedoms while balancing of the rights of children to their religious and cultural beliefs and the "need for protection" within a closed religious community relative to child development, socialization, and educational needs.

2. The effectiveness of outreach using existing child welfare networks was invaluable in obtaining immediate and unrestricted assistance from colleagues for cultural and religious knowledge, expertise, staffing assistance and placement resources, translation and legal assistance, and expertise in relation to immigration and international child welfare.

3. The limitations on the extent of local child welfare authority relative to interprovincial and international child protection matters. The absence of any effective mechanism through the Hague Convention between Canada and Guatemala—Guatemala is a signatory to the 1996 Convention and Canada is not led to coordination and verification of information from varying sources such as Israel, Quebec, Canadian Border Services, the local community, the Ontario Jewish community, former Lev Tahor members, family members of Lev Tahor members, Lev Tahor's ongoing use of social and regular media outlets, the U.S. Consulate, and Guatemalan officials.

4. The challenge of sorting through the competing and conflicting intentions of existing legislation/agency mandates to support outcomes based on the best interests of the children.

5. The effort to obtain both financial and practical support wherever possible, and to seek out local and federal government assistance.

6. The decision to assign a single media contact person to respond to demands for information, provide accurate information to the media, and responding to and correcting inaccurate statements made by Lev Tahor through social and regular media.

The agency's initial hypothesis regarding the effectiveness of a small, dedicated team of child protection workers proved invaluable in

ensuring consistent approaches and quickly developing a familiarity with the Lev Tahor beliefs and practices. Equally important was the fact that attempts by the group to mix up the family units were thwarted, as our staff were very cognizant of parent-child relationships. We established that intervention with this very insular community, employing a distinct service team, ensured an understanding of the group's beliefs and practices, and provided consistency and familiarity for both the community members and the agency.

References

Comission des Droits de la Personne et des Droits de le Jeunesse. (2015). Study of the intervention of the Director of Youth Protection and his partners in the Lev Tahor community and in potentially sectarian communities. Quebec, CA: Author.

Convention of 25 October 1980 on the Civil Aspects of International Child Abduction. (1980). The Hague, Netherlands: Hague Conference on Private International Law. Retrieved from https://www.hcch.net/en/instruments/conventions/full-text/?cid=24

Fogelman, S. (2012a, March 9). Lev tahor: Pure as the driven snow, or hearts of darkness? *Haaretz*. Retrieved from https://www.haaretz.com/pure-as-the-driven-snow-1.5203839

Fogelman, S. (2012b, March 16). When you're on the path of truth, you don't care what others say. *Haaretz*. Retrieved from https://www.haaretz.com/1.5205890

Ontario Superior Court of Justice, Chatham-Kent Children's Services v. JS, 2014 ONSC 2352, Justice Templeton, at paras 94–95.

Surkes, S. (2016, Sept. 14). Guatemalan authorities raid secretive compound of Jewish cult. *The Times of Israel*. Retrieved from https://www.timesofisrael.com/guatemalan-authorities-raid-secretive-compound-of-jewish-cult/

Keeping Amish Children Safe

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The Amish deliberately choose to be a community isolated from their "English" neighbors. In doing so, they cling to a way of life that sets them apart. They long to be independent—to be allowed to live in a way that is consistent with their faith and sustaining of their families and communities. Because of their emphasis on separation from the world and restricted interaction with outsiders, they reject higher education and use technology selectively (Kraybill et al., 2013). Their language, dress, means of transportation, educational systems, and occupational choices are ways in which they physically distinguish themselves from mainstream society.

More than 310,000 Amish live in the United States (Amish Studies, 2017). They are "growing faster than almost any other subculture, religious or non-religious, in North America" (Donnermeyer & Anderson, 2013, p. 74). Due to large family sizes and 85% of its members remaining in the faith, the Amish population doubles about every 21 years (Amish Studies, 2017). While two-thirds of Amish live in Ohio, Pennsylvania, and Indiana, the significant increase in their number is causing them to seek other places to live in order to maintain what most of them consider their ideal way of life: crop farming. Amish now live in 31 states and in three Canadian provinces.

The growth and spread of Amish communities is coming to the attention of child welfare and other professional systems. These systems must understand and respect the faith and culture of the Amish in order to be culturally competent in service delivery and to promote safety for children and families.

Theoretical Framework

One lens through which to consider the Amish faith and culture is Berry and colleagues' (1987) modes of acculturation. In this theory, acculturation is viewed as an interactive, developmental, and multi-dimensional process (Cuellar & Glazer, 1995). Put on a quadrant of maintaining their cultural identity and having contact with and participating in the host society, communities may integrate, assimilate, separate, or be marginalized.

Amish communities continually decide the degree to which they will maintain their own culture and the degree to which they will assimilate. Historically, the Amish were not as distinctive as they are now—their farming methods were similar to their neighbors, and they sent their children to public schools. Society, however, has been on a steep trajectory for change and has left the Amish far behind. The Amish do not embrace change so quickly; they carefully consider change through the lens of their faith and the threat it may introduce to the fabric of their families and communities.

Underrepresentation, Awareness, and Detection of Child Maltreatment

Since the Amish way of life is fascinating, even spellbinding, it captures the interest of onlookers. The media has surged forward in putting forth written and video images that vastly misrepresent this cultural group. Child welfare and other professional systems often feel bereft in knowing how to engage with this unique group, and consequently, may toggle between judging it too harshly or too lightly—both of which do a disservice to Amish children, families, and communities.

Since the Amish culture and faith calls on its followers to be separate from "the world," Amish children do not have frequent contact with mandated reporters, such as teachers, social workers, or medical doctors. The Amish typically provide education to their own children and do not frequent medical clinics, except in the case of trauma. The rates

of abuse and neglect within the Amish culture are unreported, as this group is not distinguishable by racial categories.

Despite their insularity, Amish children are not necessarily at an increased vulnerability to abuse and neglect. The typical Amish community has strong social support with the presence of many people of multiple generations. The community's faith and values promote strong families and provide a safety net for all members, including elders and those with disabilities.

At the same time, child welfare systems experience issues in Amish communities related to neglectful supervision of children, due in part to large families and children being cared for by older siblings. The Amish lifestyle also puts children at risk for runovers, drownings, and burns. Primitive farming and transportation factors bring the children into frequent and close contact with large animals. Amish children may be at higher risk for abuse and neglect due to undiagnosed and untreated medical and mental health conditions. Their isolated, closed communities and their lack of sex education may put Amish children at high risk for sexual abuse. At this point, the incidents of abuse and the number of child deaths among Amish communities is known only anecdotally.

In response to the numeric growth and geographic spread of the Amish, a system of clinics is emerging that provides services to this unique cultural group in the areas of medical and mental health, domestic violence, and substance abuse. Some of these clinics are run by Amish (and Old Order Mennonites), some by community professionals, and some in combination of the two. While evidence-based practice is not established in providing these informal faith-based services, established evidence-based practice methods would likely do more harm than good with this unique cultural group.

Some Amish families and communities are closer to the integration quadrant in Berry's theory of acculturation and are surprisingly open to becoming foster and adoptive families. Most children placed in these families are "English" and young (0–5 years). The Amish strong value for social justice calls them to risk ongoing interaction with the government in exchange for caring for children who need shelter and safety. The

Amish value of acceptance also predisposes them to be nonjudgmental of birth families and allows them to care for the children unconditionally and to accommodate children's contact with birth families.

Proposed Research Questions and Methods

Research methods that aim to engage the Amish as participants in data collection are very challenging to implement, especially within the subject area of child protection. Since the current body of literature on child protection with the Amish is so limited, child welfare research on this cultural group could start with the following research questions:

1. What is the rate of reported abuse and neglect among the Amish across the United States? What are the types of abuse and neglect being reported, and what are the case outcomes?

   - Current systems do not allow for the systematic collection of data to answer these questions. Therefore, considerable work must be done to collect representative data at local levels and to identify mechanisms for the collection of more systematic data at regional and state levels.

2. What are child welfare workers' and systems' experiences in interacting with the Amish in conducting assessments and investigations into cases of abuse and neglect? What strategies have and have not been successful?

   - This question could be answered through coupling content analysis of case records with worker and supervisor interviews.

3. What creative strategies have professionals used to successfully promote the safety of Amish children and the prevention of child abuse and neglect in Amish communities? Have these strategies resulted in increased safety?

   - Interviews with key informants who have established relationships within Amish communities and organized safety and health fairs would increase knowledge of options.

4. What are effective strategies for recruiting, preparing, selecting, maintaining, and supporting foster and adoptive homes within the Amish?

- Interviews with workers and supervisors at local levels and content analysis of their administrative data could help answer this question.

5. What are the practices and outcomes of outpatient and residential programs that serve Amish communities?

- Process and outcome evaluations of these programs could be completed through observation, interviews, focus groups, and analysis of existing data, if any.

Amish who are at the progressive end of the continuum, and those families who foster and adopt, could be open to participation in research, if given the consent of their communities and the understanding of how the research would not conflict with their faith and would strengthen their communities and families.

Research Implications

Little is known about effective child welfare practices with the Amish. Answering any of the questions listed above will launch a knowledge base for promoting the safety of the growing number of Amish children. Through knowledge, child welfare systems and the workers inside them can have a more informed understanding and respect for the Amish faith and culture so they can conduct assessments and investigations that help and not harm Amish families and children. Professional systems must also discover and implement methods for the promotion of child safety and the prevention of child abuse and neglect in Amish communities.

Answering the research questions outline above can potentially be beneficial to other insular and isolated communities. Katzenstein and Fontes (2017) wrote about similar research needed with the Orthodox

Jewish communities. Other conservative communities may also benefit, such as the German Baptists, Hutterites, Holdeman (Church of God in Christ), and the Old Order River Brethren.

The first four research questions outlined here could be completed in the next 5–10 years with a team of researchers working in jurisdictions with larger, historic populations of Amish, such as Holmes County, Ohio, and Lancaster County, Pennsylvania. The fifth question requires that relationships of trust with members of insular and isolated communities be built. These relationships cannot be rushed or fabricated. "Three steps forward" can easily become more than "two steps back" if the researcher betrays their confidence or impinges on their faith. Thus, a team approach is necessary with some researchers working within the child welfare system and some building relationships with Amish communities.

References

Amish Studies: The Young Center. (2017). Frequently asked questions. Elizabethtown, PA: Elizabethtown College. Retrieved from http://groups.etown.edu/amishstudies/frequently-asked-questions/

Berry, J. W., Kim, U., Minde, T., & Mok, D. (1987). Comparative studies of acculturative stress. *International Migration Review, 21,* 491–511.

Cuellar, I., & Glazer, M. (1995). The impact of culture on the family. In M. Harway (Ed.), *Treating the changing family: Handling normative and unusual events.* New York: John Wiley & Sons.

Donnermeyer, J. F., & Anderson, C. (2013). The Amish population: County estimates and settlement patterns. *Journal of Amish and Plain Anabaptist Studies, 1,* 72–109.

Katzenstein, D., & Fontes, L. A. (2017). Twice silenced: The underreporting of child sexual abuse in Orthodox Jewish communities. *Journal of Child Sexual Abuse, 26,* 752–767. doi: 10.1080/10538712.2017.1336505

Kraybill, D. B., Johnson-Weiner, K. M., & Nolt, S. M. (2013). *The Amish.* Baltimore, MD: The Johns Hopkins University Press.

Underrepresentation of the Asian American Community in Reported Cases of Child Maltreatment

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There is great dearth of research about child maltreatment within the Asian American and Pacific Islander (AAPI) community. According to the U.S. Census Bureau, Asian Americans and Pacific Islanders were the fastest growing population in the United States (2017), yet data on child abuse and neglect still demonstrates an underrepresentation of this community (Zhai & Gao, 2009). Historically, while AAPIs make up very small percentages in the child welfare system, child maltreatment still exists in this community. Research on child abuse and neglect within the AAPI community has not grown at the same rate as the population. Examining the AAPI experience through an ecological lens is essential to forming a better understanding about the contributing factors that may lead to child maltreatment and underrepresentation of the AAPI community among reported cases of child maltreatment. Furthermore, conducting a wider breadth of research on child maltreatment within insular communities such as the AAPI community can provide legislators with a greater understanding of other communities that may be overlooked by existing policies.

Target Population

In addition to the lack of research and underrepresentation in the child welfare system, the AAPI community is often lumped into one sum category due to current data collection methods. The AAPI community is not homogenous, as some data and media suggests, but

is comprised of children and families of vastly varying experiences, cultures and backgrounds. The breadth of diversity within this community cannot be encompassed in one paper, so for the purposes of this essay, Chinese American families will be used as an example to exemplify one small aspect of the AAPI community.

Chinese Americans were reportedly the largest Asian American group in the United States in the 2010 Census (U.S. Census Bureau, 2012). In a 2009 study, Chinese Americans were found to be substantially underrepresented in the child maltreatment statistics (Zhai & Gao, 2009). In a separate 2008 study, it was shown that the rate of abuse in the AAPI community was no greater than in other non-Asian communities (Lau et al., 2008). However, the study found that out of all Asian American groups, a greater percentage of Chinese American parents were found to use physical punishment tactics (Lau et al., 2008). The goal of this essay is not to incriminate parents, but to provide a better understanding of the underlying factors that perpetuate corporal punishment in the AAPI community so that it can be prevented.

While spanking is a common across all races and culture, multiple studies indicate that Asian parents are more likely to believe in the use of physical and corporal punishment in comparison to non-Hispanic white parents (Zhai & Gao, 2009). Parents may believe that using corporal punishment is an act of love and is best for the child and for the family unit, by using physical tactics to teach the child to behave in a certain way. The value placed on collectivism in Chinese culture may perpetuate this idea, as collectivism emphasizes what is best for the family over what is best for the individual (Juang, Syed, Cookston, Wang, & Kim, 2012). Parents who abide by Confucian values may feel they have the right to parent in a more authoritarian method, which can manifest through strictness or using severe discipline methods (Lau et al., 2008).

Tension between cultural values are recognized when examining why Chinese American children are underrepresented in the detection of child maltreatment. Asian American families often turn internally to fellow family members in times of need, rather than seeking outside

assistance (Chang & Ng, 2002). Values such as family cohesion and the protection of the family reputation may also prevent child maltreatment from being reported (Zhai & Gao, 2009). Thus, because Asian American families often seek help from within the family, there can be a lack of awareness about outside resources available (Zhai & Gao, 2009).

Examining from an Ecological Perspective

Numerous studies published in the early 2000's point to Confucian-influenced values of filial duty, the importance of parental authority, and putting the family needs before individual needs as possibly resulting in the use of corporal punishment (Lau, 2010). On the other hand, values such as showing proper restraint and protecting family cohesion, can also be protective factors (Lau, 2010). Further, as pointed out by Lau (2010), it would be unwise to assume that all Chinese American families operate under the same system of values and are naturally disposed to corporal punishment. Therefore, it is important to examine each family through an ecological perspective, which can provide a framework to understanding the protective factors and stressors that affect the family environment.

The ecological perspective examines a person in an environment, as well as the micro, mezzo and macro factors that may influence a person's adaptation to this environment (Robbins, Chatterjee, & Canda, 2012). This perspective proposes that all individuals are striving for a goal, which is to gain "goodness of fit", or the best compatibility with their environment (Robbins et al., 2012). Within immigrant Chinese American families, acculturation to the environment may be occurring at different rates, with second generation children adapting to American values at a faster rate than their immigrant parents (Juang et al., 2012). This can result in the children and parents having different goals to obtain their goodness of fit. Parents may desire for their children to achieve academic excellence, place family needs first and respect their elders (Juang et al., 2012). Children, on the other hand, may adopt the American value of individualism over a collectivist mentality, which can

cause a clash of cultural values known as acculturation-based conflict. Acculturation-based conflict within families can lead to conflict in even everyday life activities, such as doing homework or chores (Juang et al., 2012). Conflict within the family and other acculturation stressors faced by immigrant Chinese American parents, such as adapting to the language, economic stressors or adjusting to different social norms can lead to increased risk for parental use of physical punishment (Lau, 2010).

A 2017 study exploring the impact of family socioeconomic status, acculturation, ethnicity, enculturation and parenting beliefs was conducted of 195 mothers and 13 other family members spanning 7 different broad cultural groups within the United States (Dunst, Hamby, Raab, & Bruder, 2017). The results suggested that the three factors that had the largest influence on parenting beliefs about child behavior, methods of child learning and parenting roles were family socioeconomic status, acculturation and family ethnicity (Dunst et al., 2017). The study was conducted from an ecological perspective, in hopes of not perpetuating the idea of group-oriented culture, which is a perspective that allows for little or no variation in beliefs among individuals within the same cultural group (Dunst et al., 2017). Thus, it is important to also take into consideration a family's socioeconomic status, country of origin and level of acculturation when attempting to gain a broader understanding of the factors that may be influencing parenting beliefs. Differing parenting beliefs can also determine whether or not parents believe in utilizing physical punishment with their children, and the extent, severity and frequency to which physical punishment methods are employed.

Proposed Methods for Raising Awareness

When examining the ecological factors surrounding the AAPI community and underrepresentation of reported child maltreatment, one suggestion to working with this community is to begin from the ground up, focusing on individual communities and then later expanding to larger macro methodology. Engaging directly with the AAPI

community to educate and provide resources and assistance is important, especially for immigrant families. Further research would require multilingual and multicultural researchers who are capable of properly communicating with the families. In order to respect the privacy of the families, anonymous studies should be conducted. Cultural sensitivity about respect and privacy within these families is also necessary to raise awareness and address child maltreatment within this population.

Immigrant families may be experiencing isolation and feel they have no external places to turn for assistance, especially if no other family lives nearby (Zhai & Gao, 2009). To raise healthy children, studies indicate that it takes a collective effort from community stakeholders, such as schools, family and other community services (Benson et al., 2012). Therefore, it is important that proposed methods aim to reduce the potential for isolation by providing multilingual services, and connecting families to other families in the same communities. Services catering to the children, such as after school tutoring or extracurricular activities can be another means to reaching families. Having multilingual staff at these programs that can communicate with the parents can also increase a sense of community connectedness. Furthermore, obtaining funding to expand the breadth of culturally sensitive mental health services offered in these communities is vital to reaching out to families who may experiencing stressors and isolation.

Proposed Methods for Identifying Physical Abuse

In addition to providing support for families, it is essential to have knowledge on how to identify the signs physical abuse. These signs are present regardless of culture or race. Injuries that must be further assessed include: any injury on an infant, more than one injury in different stages of healing, injuries that take on some type of pattern, injuries in non-bone areas of the body such as the face, stomach, thighs or buttocks, or any unexplained injuries (Christian, 2015). When a suspicious injury is spotted, it is important to speak to the child separately from the parent. The child should be asked about the events surrounding the

injury, how it occurred and if treatment was given for the injury (Christian, 2015). If the child is non verbal, the parent may be questioned instead. When engaging with the child and parent, it is pertinent to not suggest nor assign blame to any one party and to keep a non-accusatory tone (Christian, 2015). When working with families, services providers must be sensitive to the fact that family culture may cause a parent or child to hesitate to disclose how an injury occurred, whether it was by abuse or not.

Proposed Methods for Research

In order to gain an accurate scope of understanding of child abuse and neglect in insular communities such as the AAPI community, it is essential to utilize a mix of both qualitative and quantitative methodology in research. Qualitative research focuses more on the experiences, or the "what, how, why" of an occurrence, while quantitative research focuses on the numbers, the "how much" and "how many" (McCusker & Gunaydin, 2015). Using one without the other can result in unbalanced results. Focusing only on quantitative methods can miss the experiences and perceptions of the community being studied, and utilizing only qualitative methods may miss certain larger context trends that only raw numerical data can capture. The use of quantitative research is often more common, as it is more cost and time efficient to gather numerical data ((McCusker & Gunaydin, 2015). The same amount of time applied to qualitative research will cover a smaller sample size, as it takes time and resources for the researchers to go out into the community and conduct interviews with individuals. When examining the phenomenon of child abuse and neglect, it is important to understand the experiences of the families as well as the contributing factors surrounding the family and the community. Therefore, the use of quantitative data is essential in gaining a deeper understanding of the family experience. Much of the existing data on child abuse and neglect within AAPI communities has been gathered through quantitative methods from data voluntarily collected by child welfare agencies and submitted

to the National Child Abuse and Neglect Data System (NCANDS), further showing how quantitative data and studies are lacking in this area. While there are many potential limitations to collective qualitative research within these communities, one particularly blatant limitation is confidentiality. Families involved in the child welfare system have their confidentiality protected by law, and from an ethical standpoint, families involved in the studies regardless of their involvement in the child welfare system should have their confidentiality protected. One way that NCANDS was able to resolve this limitation was to double-encrypt all identifying information from their data collection (NCANDS). Doing so will help prevent the confidentiality of the families in these studies from being broken (National Child Abuse and Neglect, 2012).

Implications for Policy

Some Asian American immigrants come from countries where there is no formal child welfare system, and therefore may be unfamiliar with the laws and child welfare system in the U.S. (Lee, Fuller-Thornson, Fallon, Black and Trocme, 2017). This concept can also be applied to immigrants from other countries who do not have formal child welfare systems. Therefore, families may not be aware of the laws surrounding corporal punishment, and may be too fearful of the child welfare system to seek assistance from community based resources. Secondly, some researchers suggest that culturally specific community resources may be lacking for those in the AAPI or other insular communities (Lee et al., 2017), leading to further feelings of isolation which can then perpetuate the current stressors and continue the cycle of abuse or neglect. Finally, underlying or implicit biases surrounding the AAPI community may prevent service providers from spotting abuse or neglect, or prevent the family from being referred to community resources (Lee et al., 2017).

With all of the knowledge gained from cultural differences that interplay into child abuse and neglect, when it comes to policy, it is of the utmost importance to ensure that policy making comes from a lens of treating all humans with an equal level dignity and respect.

Allowing biases to get in the way of assessment can lead to the over or under representation of specific groups in the child welfare system. One way to combat this is to create policies that provide more in-depth trainings that equip child welfare workers and service providers with the skills on how to assess for child abuse and/or neglect across cultures. It is important to conduct the trainings in a way that allows for the sharing of experiences in a culturally sensitive manner, and to hear the stories and experiences of those of differing cultural backgrounds. Trainings must be careful to not create a list of stereotypes to look for within each group, but to better equip service providers on how to improve their assessment skills and put aside bias, especially implicit biases that one may be unaware of. Training staff specifically to spot and be able to report and prevent child abuse and provide early interventions can ensure the family receives proper services.

Conclusion

Overall, it is essential for researchers and service providers to be mindful that the AAPI community is diverse in their needs, experiences and backgrounds – children may have an immigrant mother and an American-born father, or be immigrants themselves. Family values and cultural norms will differ vastly depending upon the country of origin and even depending upon which area within their country of origin they are from. Furthermore, socioeconomic status of the family is another factor that contributes to the diverse experiences within this community. Exploring further the impacts of country of origin, socioeconomic status and level of acculturation can produce a more broadened understanding of the factors that impact parenting beliefs, thus allowing service providers to work more effectively with the communities they serve. Maintaining a vigilant eye, operating from a lens of cultural humility and not allowing prior biases to create false assumptions is a vital step to decreasing child maltreatment, not just within the AAPI community but within other communities as well. More research is needed about the individual groups that make up the AAPI community to provide a better framework on

how to best engage and develop a greater understanding of these families' experiences, and hopefully transform this population from being an insular community to one that is widely recognized and served. The insight gained from additional research can also provide further direction on how to best identified underlying needs within families and prevent child abuse and neglect, regardless of a family's culture or background.

References

Benson, P. L., Leffert, N., Scales, P. C., & Blyth, D. A. (2012). Beyond the "Village" Rhetoric: Creating Healthy Communities for Children and Adolescents. *Applied Developmental Science*, *16*(1), 3–23. DOI: 10.1080/10888691.2012.642771

Chang, H. H., & Ng, K. S. (2002). The Perception of Resiliency Mechanisms in Chinese American Families: Implications for Family Therapy. *Family Therapy* 29(2). Retrieved from http://search.proquest.com.libproxy1.usc.edu/docview/1474306502?accountid=14749

Dunst, C. J., Hamby D. W., Raab, M., & Bruder, M. B. (2017). Family Socioeconomic Status and Ethnicity, Acculturation and Enculturation, and Parenting Beliefs about Child Behavior, Learning Methods, and Parenting Roles. *Journal of Education and Culture Studies*, *1*(2), 99–122. doi:10.22158/jecs.v1n2p99

Juang, L. P. Syed, M., Cookston, J. T., Wang, & Y., Kim, S. Y. (2012). Acculturation-Based and Everyday Family Conflict in Chinese American Families. *U.S. New Directions for Child and Adolescent Development*, *135*, 13–34. DOI: 10.1002/cd.20002

Lau, S. A. (2010). Physical Discipline in Chinese American Immigrant Families: AN Adaptive Cultural Perspective. *Cultural Diversity and Ethnic Minority Psychology*, *16*(2), 313–322. DOI: 10.1037/a0018667

Lee, B., Fuller-Thomson, E., Fallon, B., Black, T., & Trocme, N. (2017). Examining Child Welfare Decisions and Services for Asian-Canadian Versus White-Canadian Children and Families in the Child Welfare System. *Child Maltreatment*, 22(2), 132–144. https://doi-org.libproxy2.usc.edu/10.1177/1077559517690829

McCusker, K., & Gunaydin, S. (2015). Research using qualitative, quantitative or mixed methods and choice based on the research. Perfusion. *30*(7), 537–542. https://doi-org.libproxy2.usc.edu/10.1177/0267659114559116

National Data Archive on Child Abuse and Neglect (NDACAN) (2012). National Child Abuse and Neglect Data System (NCANDS) Child File FFY 2012. Ithaca, NY: Brofenbrenner Center for Translational Research Cornell University. Retrieved from https://www.ndacan.cornell.edu/datasets/pdfs_user_guides/Dataset178NCANDS-CF-UsersGuideFY2012.pdf

Robbins, S. P., Chatterjee, P., & Canda, E. P. (2012). *Contemporary Human Behavior Theory: A critical perspective for social work.* Upper Saddle River, NJ: Allyn & Bacon.

United States Census Bureau. (2012). The Asian Population: 2010. Retrieved from https://www.census.gov/prod/cen2010/briefs/c2010br-11.pdf

United States Census Bureau (2017). United States Census. Retrieved from: https://www.census.gov

Zhai, F., Gao, Q. (2009). Child Maltreatment Among Asian Americans. *Characteristics and Explanatory Framework. Child Maltreatment*, 14(2), 207–224. DOI: 10.1177/1077559508326286

Dual Marginalization of Urban-based American Indian and Alaska Native Children and Families

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Urban-based American Indian and Alaska Native children and families (herein referred to as "Native" or "Native people") who become involved with public child welfare systems experience a dual marginalization—both within the urban environments in which they live and within public child welfare systems. (In this essay, the authors use the term "urban" inclusively to refer to small towns and cities, as well as large metropolitan areas, that are located outside the boundaries of a reservation or tribally controlled area. When Native children domiciled in these urban areas first become a part of a child welfare action, they will come under the jurisdiction of a state or county CPS system, not a tribal system, as would a Native child living on a reservation.) While CWLA's call for essays asks authors to address groups who may be insular or isolated, we are reluctant to position urban-based Native people using these terms. Considering Native people as insular using commonly accepted definitions such as "constituting an island" or "characteristic of an isolated people," or having a narrow-minded viewpoint (insular, 2017), risks perpetuating stereotypic beliefs and images of Native people that are both overt, and arguably, that lie deeply embedded and largely unexamined in the American psyche. Commonly held stereotypes of Native people as isolated and insular fail to depict their contemporary and empowered agency, and they are also problematic in that they presume that being set apart from the American social structure was the group's choice. Importantly, they also ignore the

history of genocidal, political, and socioeconomic realities that have contributed to Native marginalization in the United States.

In this essay, we ask that readers shift their thinking about urban-based Natives from insular or isolated to considering them to have come to occupy a marginalized social position due to several centuries of governmental policies and actions, resulting in highly impactful group losses and an accompanying sequela of biopsychosocial, political, and economic responses. Together, these factors now manifest as a type of structural marginalization affecting urban Native children and families in forms such as poverty, residency patterns that keep group members separated, high levels of trauma exposure, substance abuse, suicide, domestic violence and crime victimization perpetrated by non-group members, and a lack of culturally-based services. Structural marginalization also continues to be reinforced by images and social discourse that positions Native people outside of contemporary urban life and results in a social blindness to the contemporary realities of urban Native people, although various sources find that, depending upon the definition of an urban location used in analysis, 50–75% now live outside reservations or tribal trust lands (First Nations Development Institute, 2017; Norris, Vines, & Hoeffel, 2012). Thus, our argument is that Native families may be particularly impacted by contextual factors related to their structural marginalization with urban settings that can exacerbate the types of social-emotional challenges, which if not addressed, are known to increase risk of caregiver trauma which, in turn, increases risk for child abuse and neglect. To ensure well-being, urban American families need on-going connections to their native cultures, extended family and kinship systems and access to an array of culturally-based community services.

Contributory Factors to Native Marginalization

Lack of Social, Cultural, and Traditional Spiritual Supports

Marginalization may result when urban Native families lack the social, cultural, and spiritual supports recognized as being protective factors

against child abuse and neglect. Most U.S. cities do not have areas in which large numbers of Native people live in neighborhoods or close to one another. Instead, Native people tend to be dispersed across wide geographic areas. Current Native residency patterns in some cities have resulted from intentional policy decisions during the Relocation era of the 1950s and 1960s, which sought to force assimilation by preventing Native people from connecting with one another in their new non-reservation settings (Fixico, 2000; Willard, 1997). In Lucero's (2009) study of multigenerational Native urban living, many participants reported that despite wanting social contacts with other Native people in their city, they had few such contacts and felt they would have to work especially hard to find these contacts. These individuals also felt separate and apart from non-Natives in their cities. In most urban areas, cultural activities occur infrequently, and few traditional spiritual leaders reside in urban areas, making it difficult for Natives to take part in ceremonies and other cultural practices that have been utilized for millennia for healing and balance.

Marginalization of urban Native people is also exacerbated by geographic isolation from their tribal communities. Enrolled members of American Indian/Alaska Native tribes who are living off-reservation in urban areas may experience disconnection from family members, community relationships, and cultural and spiritual rituals, traditions, and resources. A percentage of urban-based Native people are not tribally enrolled due to factors beyond their control, such as blood quantum levels falling below enrollment minimums, having parents or grandparents who were never enrolled or were denied enrollment, or descending from families whose members' connection to their tribe was severed through non-Native adoption. Not being officially recognized as a tribal member may leave some urban Natives feeling further marginalized from their tribal communities and distanced emotionally as well as geographically from the benefits of tribal citizenship, acceptance, and community. Formal enrollment in a tribe, however, is largely independent of an individual's cultural self-identity as a Native person and of experiencing others' negative stereotypes. Thus, non-tribally enrolled urban Native

people may experience the deleterious effects of the marginalization faced by all Native people, but without the balancing protective factors of tribal membership and tribal community connections.

Native Marginalization in Child Welfare

Urban Native families may then experience an additional layer of marginalization within public child welfare systems that results from these systems: (1) not identifying Native children and families within their systems; (2) having difficulty understanding or recognizing the manifestations of trauma and toxic stress that urban Native people may experience and which are compounded by structural marginalization; and (3) failing to provide services that are both culturally-relevant and that address marginalizing factors. The marginalization experienced by Native people within CPS systems is an important factor in the group being *overrepresented but underserved*—overrepresented in public child welfare and underserved by both child welfare and the collateral community-based services system with which child welfare frequently works.

Public child welfare systems continue to be slow to identify American Indians and Alaska Natives coming into their systems; numbers of Native children and families are at this moment unidentified. Once families are identified as Native, cultural differences can create barriers between workers and families that child welfare workers may be unprepared to overcome. This can result in caseworkers feeling powerless or worrying about doing something culturally inappropriate. Despite not living in their tribal homelands, many urban Native people continue to structure their lives, behaviors, and relationships in ways congruent with tribal values and practices. But when involved with the child welfare system, these values, behaviors, and relationships, which can represent actions toward empowerment, agency, and continued survivance for Native peoples, may appear foreign or disconcerting, or even be interpreted as indicating some pathology. Actions and attitudes that result from or are attempts to cope with the marginalization that Native

people may experience in the urban environment, can be turned back upon them as indicators that something is wrong with a caregiver, with the family, or in the raising of children. Caseworkers may also be unfamiliar with what constitutes culturally appropriate community-based services, and a community may have few clinicians and other providers experienced in working with Native people. And, finally, Native families may be unfamiliar or uncomfortable with navigating dominant culture service delivery systems and have difficulty expressing to their child welfare worker that services are not culturally congruent or not meeting their needs.

Addressing Marginalization within the Child Welfare System

The ideas put forth in this essay support several theoretical premises of Indian Child Welfare practice and are in alignment with what many tribes would consider to be foundational knowledge for culturally responsive child welfare service delivery: (1) urban Native families consist not only of children and their parents/caregivers, but are networks of kin and non-kin relationships; (2) these families are integral parts of the urban Indian and tribal communities to which they have historical and ongoing connections; (3) disruptions and struggles within Native families impact these communities, and likewise, as families heal, so do Native communities; and (4) addressing urban Native marginalization within the child welfare system requires expanding service approaches and service options for Native families.

Public child welfare agencies can work to enhance engagement and service delivery for currently underserved Native families by creating and sustaining partnerships with community-based agencies, court systems, tribal child welfare programs, and tribal colleges and schools of social work across the country. These partnerships can be a critical strategy for forming service delivery networks that are committed to providing culturally appropriate service delivery and attending to urban Native families' cultural needs. Child welfare and state and

county courts must together do a better job implementing effective strategies for prevention, early identification of urban Native children and families, and timely referral into a culturally appropriate service delivery network—both to provide culturally appropriate assessment and targeted services and ensure Indian Child Welfare Act (ICWA) compliance. Early identification, when coupled with culturally appropriate intervention and service delivery, has been shown to prevent removal of children from their homes while addressing the well-being of urban Native families. Additionally, culturally based interventions must address the historical and contemporary trauma of urban Native families that so frequently manifest as substance abuse, mental health disorders, family disorganization, and family violence.

A culturally based approach to service delivery is not only critical for Native families, but also for other marginalized ethnic groups living in urban settings. Adaptation of the strategies outlined herein may be relevant for refugee populations fleeing the trauma of war, political persecution, and famine. Like Native people decades before, refugees coming to urban settings may experience the shock of relocation and of being separated from kin and community, while also finding themselves in a marginalized position within the ethnic mix of U.S. cities. And thus, Native models of culturally-based services and community responses may also provide guidance in developing services to support the health and well-being of refugee families.

References

First Nations Development Institute. (2017). *Twice invisible: Understanding rural Native America.* Longmont, CO: First Nations Development Institute.

Fixico, D. L. (2000). *The urban Indian experience in America.* Albuquerque, NM: University of New Mexico Press.

insular. 2017. In *Merriam-Webster.com*. Retrieved from https://www.merriam-webster.com/dictionary/insular.

Lucero, N. M. (2009). *The evolving nature of cultural connectedness: Perspectives from four generations of urban American Indians.* Unpublished manuscript.

Norris, T., Vines, P. L., & Hoeffel, E. M. (2012). *The American Indian and Alaska Native Population: 2010; U.S. Census Brief.* Washington, DC: Department of Commerce. Retrieved from https://www.census.gov/prod/cen2010/briefs/c2010br-10.pdf

Willard, W. (1997). Outing, relocation, and employment assistance: The impact of Federal Indian population dispersal programs in the Bay Area. *Wicazo Sa Review, 12*(1), 29–46.

Child Maltreatment in Insular and Isolated Communities: Families who are Asian American in Riverside County

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There is a substantial amount of research that has addressed the overrepresentation of certain racial and ethnic populations, mainly African Americans and Native Americans, in the child welfare system compared to their representation in the general population (Derezotes, Poertner, & Testa, 2004; Wells, 2011; Summers, 2015). Further, several studies have indicated that racial disparities and disproportionality occur at various decision points in the child welfare continuum (Detlaff et al., 2011; Font 2013; Putnam-Hornstein, Needell, King, & Johnson-Motoyama, 2013). Much of the current research is more focused on disproportionality from the viewpoint of overrepresentation of minorities in the child welfare system.

Since 2012, the Riverside County Department of Public Social Services (DPSS)—Children's Services Division (CSD) has acknowledged the problem of overrepresentation of certain racial and ethnic minorities in the child welfare system and proactively formulated and implemented possible solutions. This focus aimed to address the long-standing concern of overrepresentation of children who are African American and Native American in all decision points in the child welfare continuum: reporting, investigation, substantiation, placement, and exit from care. These efforts sought to highlight the experiences of children who are African American and Native American in the child welfare system. The intent was to better understand

decision-making and how influencing those decisions might impact the federal measures of reducing a child's reentry into the child welfare system and increasing permanency for a child.

There has not been an effort to look at certain racial and ethnic groups that are underrepresented in Riverside County's child welfare system such as families who are Asian American. It should be noted that societies and cultures as symbolic systems have come under criticism and scrutiny that they are not as closed or isolated as they previously were due to the advancement in communication technology. For analytical purposes the idea of ethnic groups, societies, or cultures as entities that can meaningfully be isolated has not been rejected. For Riverside County, this will be a unique opportunity to get a closer look at Asian American culture in order to better understand what factors or reasons led this population to be underrepresented in the system compared to the general population. Are there protective factors or strategies being used within this group in avoiding or decreasing child maltreatment?

Theoretical Framework

Fluke, Harden, Jenkins, and Ruehrdanz (2011) asserted that the term "racial disproportionality" was created as a way to explain the phenomenon of overrepresentation and underrepresentation of certain racial and ethnic groups in the child welfare service sector. According to Garcia Coll, Akerman, & Cicchetti (2000), it is important to recognize that racial and ethnic groups are not the same. Fluke and colleagues (2011), pointed to the fact that there is significant within group variability that is not shown through the simplistic measures of race and ethnicity. Therefore, it should be noted that racial and ethnic groups are not uniformly overrepresented or underrepresented in the current child welfare setting (Fluke et al., 2011).

The child welfare literature points to culture as a key factor in understanding issues with regards to overrepresentation or underrepresentation of certain racial and ethnic groups in the child welfare system.

For example, Lee, Rha, and Fallon (2014) contend it is important to understand how cultural differences in perspectives and practices might influence social workers in their decision making. Using this model, the removal or provision of services to the families is based on a decision of the child protective social worker to accept behaviors as culturally appropriate. The same child protective social worker might enforce inflexible cookie-cutter standards of service in the name of safety, well-being, and permanency as outlined in policy or legislation and provide services that do not acknowledge different cultural values, beliefs, and practices (Roer-Strier, 2001; Dettlaff & Rycraft, 2008).

In their review of 10 years of research on overrepresentation and underrepresentation in child welfare system, Fluke and colleagues (2011) acknowledge the difficulty in determining what specific factors at either the system level or individual case level contributes to differential patterns of representation and outcomes in child welfare services. However, they pointed to four probable explanations as influencing the discrepancy:

- Disproportionate and disparate needs of children and families of color, particularly due to higher rates of poverty
- Racial bias and discrimination exhibited by individuals such as caseworkers, mandated and other reporters
- Child welfare system factors such as lack of resources for families of color and caseworker characteristics
- Geographic context such as the geographic region, state, or neighborhood

Target Population

The target population for this study is families who are Asian American. The reason for underrepresentation of this group in the child welfare system in Riverside County is not clear. Issues to be explored include determining if there is underreporting of maltreatment for children who are Asian American or if there is a lower occurrence of maltreatment

among this population. Table 1 shows 2017 Riverside County disparity indices for children who are Asian American compared to those who are African American, Caucasian, Latino, and Native American.

Further, there are no identified studies that have been conducted concerning the population regarding cultural protective factors. Cheung and LaChapelle (2011), as well as Maguire-Jack, Lanier, Johnson-Motoyama, Welch, & Dineen (2015), contend that underrepresentation could be a result of cultural perceptions of others or this population might be less likely to report maltreatment due to cultural norms. In their study of Canadian child welfare experience for families who are Asian, Lee, Rha, and Fallon (2014) found there are differences in definitions of family and kin relations between Western culture and Southeast Asian culture which impact families brought to the attention of the child welfare system. Figure 1 shows 2017 Riverside County percentages of representation for children who are Asian American at all child welfare services decision points compared to their percentage in total child population. This group of children has the lowest representation for all ethnicities throughout.
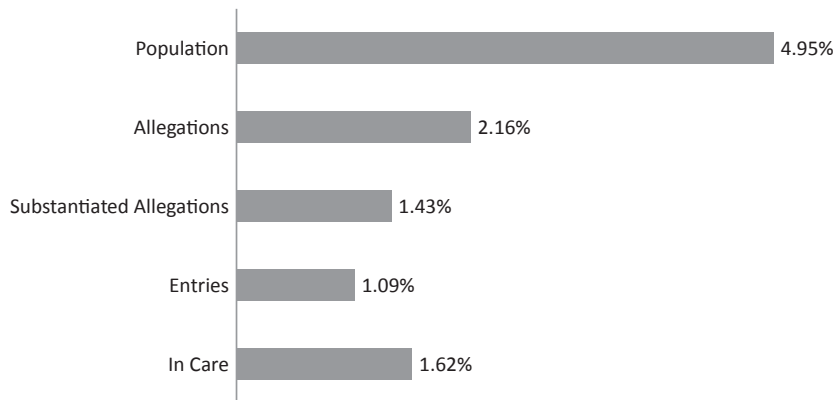
Study Methodology

Studying culture requires flexibility in methodology: qualitative methods are flexible and can adapt to the families' changing circumstances, account for the unexpected data, and could uncover processes or factors that were not previously identified as a source for low or decreased child maltreatment in Asian American communities. This study will utilize a mixed methods research design in looking at factors and/or evidence-informed strategies that contribute to low reporting of or substantiated incidences of child maltreatment in Asian American communities. The combination of both qualitative and quantitative methods allows the researcher to obtain a better understanding of the social world (Caracelli & Greene, 1993). Research findings can be generalized through the use of quantitative data while providing individual voices through the use of qualitative data (Tashakkori & Teddlie, 2003). A mixed methods

Table 1. Riverside County—Disparity Indices, Children who are Asian American, 2017

|	(n)	(1) (%)	Child Population (n)	Child Population (%)	Rate per 1,000	Compared with Black	Compared with White	Compared with Latino	Compared with Native American
Allegations	807	2.16%	28,456	4.95	28.36	0.19	0.43	0.48	0.17
Substantiated Allegations	68	1.43%	28,456	4.95	2.39	0.14	0.29	0.30	0.11
Entries	14	1.09%	28,456	4.95	0.49	0.08	0.22	0.24	0.10
In Care	52	1.62%	28,456	4.95	1.83	0.11	0.32	0.38	0.15

Source: CWS/CMS 2017 Quarter 4 Extract: Retrieved 4/02/2018, from University of California at Berkeley California Child Welfare Indicators Project website. URL: http://cssr.berkeley.edu/ucb_childwelfare.

Figure 1. Riverside County—Children who are Asian American and Involved in Child Welfare, 2017

research design generates a deeper understanding of research by using the strengths of qualitative and quantitative research to inform both (Creswell & Plano Clark, 2007).

In order to determine the impact of services to this population in Riverside County, different databases will be queried to review quantitative and qualitative data. Internal databases will be used to pull cases and to drill down into the data. These case reviews will identify what culturally relevant services were provided to families in Family Maintenance case status. The hypotheses include that those services provided, along with other identified factors, will indicate what impact occurs to the federal Child and Family Services Reviews (CFSR3) measures P1-Permanency in 12 months for children entering foster care and P4-Reentry to foster care in 12 months, within a one (1) to two (2) years' timeframe. To date, data examined from the three (3) largest ethnic subgroups in Riverside County point to very different outcome performance patterns in the areas of permanency and re-entry and may point to dissimilar experiences while in care. The quantitative data will categorically describe,

measure, and predict aspects of the child welfare experiences of families who are Asian American found in Riverside County Child Welfare services.

To supplement the quantitative data, qualitative data from specific cases will be used from case studies as detailed below by a case analysis diagram. Twelve cases will be purposively selected from the list of 100 randomly selected Federal Reviews cases for Riverside County Quality Assurance (QA) team. These case reviews include records examined from the statewide case management system and follow up interviews that the QA team conducts. The twelve cases selected ensure an increased variation based on the status of the child welfare case, such as Family Maintenance (FM), Family Maintenance Voluntary (FMV), Family Reunification (FR), and Adoption. The selected cases will provide demographic information (age, race, gender and ethnicity) and identify services provided to the clients whether or not the service provision was culturally sensitive and appropriate regarding the clients' culture. Qualitative data will include text from the twelve cases and follow up client interview notes by the QA team, which will be developed into themes. This will help to have a deeper understanding of cultural variations within Asian American families and shed light on how these families think and feel regarding their experiences.
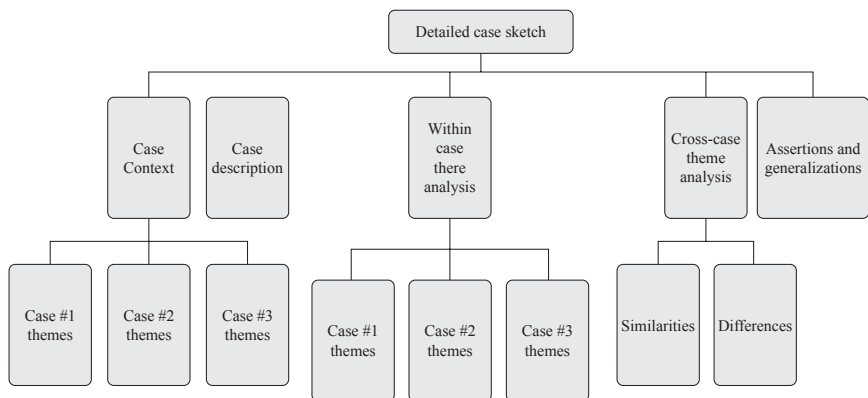
Case analysis diagram recreated, as per Creswell (2006).

Policy and Practice Implications

The possible findings would have policy and practice implications. Using a mixed-methods approach allows for the quantitative data to point toward areas for further exploration, while the qualitative data informs social work practice.

Case reviews might assist in the identification of social worker implicit bias and institutional bias. Findings on either hypothesis might identify potential benefits for specific staff training or revision of polices. Staff training in cultural humility might be indicated to include engagement strategies with families who are Asian American; acknowledging staff assumptions about the behaviors of families who are Asian American, and training on how to ensure that the families' opinions are heard throughout the child welfare case, is paramount to assisting those families. The language used in the policies might need to be changed to be more descriptive and specific to working with families who are Asian American. Practice is captured in the qualitative data collected. As bias impacts practice, it thereby impacts data. This research will further impact future decision-making based on the skewed data (Capatosto, 2017).

Underrepresentation is not inherently negative. The decision to take a closer review is twofold: (1) identifying factors that indicate lower incidence of abuse might be expanded to serve other families in populations that are underserved; and (2) ensuring that this population receives the services that might be needed to provide for the safety and well-being of children who are Asian American in Riverside County. The findings from this study could serve to improve child welfare practice, as the findings might be applicable to other populations. The case reviews might help in identifying any social workers' implicit bias or institutional bias at different decision points in a case. Looking at an underserved population will have a systemic impact as part of Riverside County's commitment to continuous quality improvement.

References

Capatosto, K. (2017). *Foretelling the future: A critical perspective on the use of predictive analytics in child welfare.* Columbus, OH: Kirwan Institute for the Study of Race and Ethnicity. Retrieved from http://kirwaninstitute.osu.edu/wp-content/uploads/2017/05/ki-predictive-analytics.pdf

Caracelli, V. J., & Greene, J. C. (1993). Data analysis strategies for mixed-methods evaluation designs. *Educational Evaluation and Policy Analysis*, *15*(2), 195–107.

Cheung, M., & LaChapelle, A. (2011). Disproportionality from the other side: The under-representation of Asian American children. In D. K. Green, K. Belanger, R. G. McRoy, and L. Bullard (Eds.), *Challenging racial disproportionality in child welfare: Research, policy, and practice* (pp. 131–139). Washington, DC: CWLA Press.

Creswell, J. W. (2006). *Qualitative inquiry and research design: Choosing among five approaches*. Thousand Oaks, CA: Sage Publications.

Creswell, J. W. & Plano Clark, V. L. (2007). Designing and conducting mixed methods research. Thousand Oaks, CA: Sage Publications.

Dettlaff, A. J., Rivaux, S. L., Baumann, D. J., Fluke, J. D., Rycraft, J. R., & James, J. (2011). Disentangling substantiation: The influence of race, income, and risk on the substantiation decision in child welfare. *Children and Youth Services Review, 33,* 1630–1637.

Dettlaff, A. J., & Rycraft, J. H. (2008). Deconstructing disproportionality: Views from multiple community stakeholders. *Child Welfare*, *87*(2), 37–58.

Font, S. A. (2013). Service referral patterns among Black and White families involved with child protective services. *Journal of Public Child Welfare, 7,* 370–391.

Fluke, J., Harden, B. J., Jenkins, M., & Ruehrdanz, A. (2011). *A research synthesis on child welfare disproportionality and disparities.* Washington, DC: Center for the Study of Social Policy. Retrieved from https://www.cssp.org/publications/child-welfare/alliance/Disparities-and-Disproportionality-in-Child-Welfare_An-Analysis-of-the-Research-December-2011.pdf

Garcia Coll, C., Akerman, A., & Cicchetti, D. (2000). Cultural influences on developmental processes and outcomes. *Development and Psychopathology*, *12*(3), 333–356.

Lee, B., Rha, W., & Fallon, B. (2014). Physical Abuse among Asian Families in the Canadian Child Welfare System. *Journal of Aggression, Maltreatment and Trauma*, 23, 532–551.

Maguire-Jack, K., Lanier, P., Johnson-Motoyama, M., Welch, H., & Dineen, M. (2015). Geographic variation in racial disparities in child maltreatment: The influence of county poverty and population density. *Child Abuse & Neglect, 47,* 1–13.

Putnam-Hornstein, E., Needell, B., King, B., & Johnson-Motoyama, M. (2013). Racial and ethnic disparities: A population-based examination of risk factors for involvement with child protective services. *Child Abuse & Neglect, 37,* 33–46.

Roer-Stier, D. (2001). Reducing risk for children in changing cultural contexts: Recommendations for intervention and training. *Child Abuse and Neglect*, 25, 231–248. doi: 10.1016/0145-2134(00)00242-8.

Tashakkori, A., & Teddlie, C. (2003). *Handbook of mixed methods in social and behavioral research.* Thousand Oaks, CA: Sage Publications.

Webster, D., Armijo, M., Lee, S., Dawson, W., Magruder, J., Exel, M., Cuccaro-Alamin, S., Putnam-Hornstein, E., Wiegmann, W., Rezvani, G., Eyre, M., Sandoval, A., Yee, H., Xiong, B., Benton, C., White, J., & Cotto, H. (2018). *CCWIP reports*. Berkeley, CA: University of California, Berkeley, California Child Welfare Indicators Project.

Using Cultural Interpreters with the Orthodox Jewish Community

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While it is difficult to imagine being isolated while living in major urban centers such as New York City, the New York–New Jersey metropolitan Orthodox Jewish Community (OJC) has a number of religious and cultural traditions that separate it from mainstream society and impact the medical evaluation and reporting of suspected child maltreatment (CM). The OJC is composed of numerous groups such as the Hasidim which differ from the "modern" orthodox community that incorporates secular culture. While not related to geography, per se, the OJC does experience religious, cultural, and other sources of isolation, living in major urban areas yet enclosed by symbolic borders, or *eruvs*, and with its own education system concentrating on Judaic studies and minimal secular education (Schick, 2009; Cooperman & Smith, 2013). Within a 75-mile radius of Brooklyn, there are a mixture of sects in networks extending from Upstate New York to Long Island and to Lakewood, New Jersey, and it has been estimated that at least 500,000 of New York City's 8.5 million population are part of the OJC and live in well-defined geographic areas (Gallagher, 2009). Fertility rates for OJC families are more than double that of the general population (Cohen, Ukeles, & Miller, 2012),

thus the number of families and the number of children in those families is not small.

Members of the OJC are isolated in a number of ways. They generally do not watch television, listen to radio, or read materials in the popular press. Groups within the OJC have created their own schools and community agencies, thus members usually interact minimally with people outside their community and look to their community's leaders for guidance and information. Consequently, it is believed that members of OJC generally do not receive injury prevention or other public health messages, although this information is increasingly being distributed at the direction of their community leaders (Jewish Community Health Initiative, n.d.). This is not without harm as we have seen infection outbreaks (Blank, Myers, Pathela, et al., 2012; Lighter-Fisher, Phillips, Stachel, et al., 2016; Rosen, Arciuolo, Khawja, Fu, Giancotti, & Zucker, 2018) and CM that reflect this isolation (Blank, et al., 2012; Greenbaum, 2002; Rosmarin, Pirutinsky, Appel, Kaplan, & Pelcovitz, 2018).

Isolation can result in fewer children being identified with CM. Historically, neglect is more common than abuse in New York, and an important number of child injuries are the result of neglect or inadequate supervision (U.S. Department of Health & Human Services, 2018). Members of the OJC often have large families with many children—a risk factor for injury resulting from inadequate supervision (Hymel and the Committee on Child Abuse and Neglect, 2006). All U.S. states have some form of mandated reporting of suspected CM (Palusci & Vandervort, 2014), and medical providers are an important source of CM reports. However, an important number of OJC children are specifically directed away from emergency departments to private practitioners who are part of their community (Holter & Friedman, 1968). Children of the OJC may then be less likely to be reported for suspected CM. In cases with more significant injury requiring a specialist or hospital-based care, the OJC has established networks of private volunteer ambulance services to provide both child and adult OJC members with expert stabilization and medical transport

(see www.hatzalah.org). Using knowledgeable leaders in the community in a model of "cultural elders," OJC members are directed to "outside" hospitals and services, which are thought to provide superior care while potentially decreasing the risk of CM reporting.

When they do seek care outside the OJC, privacy concerns and fear of government involvement can lead OJC members not to reveal to medical staff how an accidental injury occurred, creating misunderstandings that can sometimes engender antagonism and frustration among both families and mandated reporters (White, Wastell, Smith, et al., 2015). Difficulties can also arise because of their fear of spreading *leshon ha-ra* (derogatory speech about another person) or *mesira* (informing on Jews to secular authorities) (Brofsky, 2017). While strong networks and social systems are protective factors at higher ecological levels, cultural practices such as refusal to share personal or family information to those perceived to be outside the community can hinder the medical evaluation of children for potential CM. Suspicions of CM may arise when incomplete or no medical history information is presented, for example, to explain how an injury occurred (Christian and the Committee on Child Abuse and Neglect, 2015).

These practices can conflict with state laws that require reporting CM by health care professionals and hospital social workers. While medical providers have traditional duties to maintain patient privacy and confidentiality, they are also required by law to report suspected child abuse and neglect. Jewish law and scholarship recognize this potential *halakhic* problem that emerges if patient confidentiality must be broken because it is biblically mandated not to slander your neighbor (as included in Leviticus 19:16, Proverbs 25:9, and Psalms 34:14). Thus, while divulging confidential patient information can be considered grounds for professional negligence, it is noted to actually be obligatory by Jewish law when required for the safety of the patient and the public when child abuse is suspected (Brofsky, 2017; Dollin & Roth, 2018). Despite this, it has been our experience that a reported family often perceives this process and any untoward outcomes as the fault of the hospital and medical providers involved.

To address cultural issues in health care, cultural competence has gained attention from health care policy-makers, providers, and insurers as a strategy to improve quality and eliminate racial/ethnic disparities (Betancourt, Green, Carrillo, & Park, 2005). The goal of cultural competence is to create a health care system and workforce that are capable of delivering the highest quality care to every patient regardless of race, ethnicity, culture, or language proficiency. Integrated models of care and safety have been proposed for use in hospital settings, including multidisciplinary child protection teams (Connolly, 2012; Draus, 2017; White et al., 2015). Given these concerns, a goal for a culturally competent medical program should be to avoid cultural obstacles which may lead to under- or over-reporting of child abuse and neglect, the consequences of which have been noted (Raz, 2017).

New York University Langone Health encompasses hospitals, clinics and physicians' offices in the metropolitan area where a number of young children are assessed for potentially neglectful injuries. Our patient liaison department and child protection committee used a cultural competence model as the basis for a program to improve the care of OJC children with suspected abuse and neglect. We first looked at one model which has been described for use in an ultra-orthodox community in Israel (the *Haredi*) to address the group's specific internal cultural codes. It uses preparation for the encounter, conventional Haredi language, and intervention between rabbinical and professional authorities (Band-Winterstein & Freund, 2015). Realizing that a response which went beyond language was needed, we then implemented a program in two hospitals of "cultural interpreters" who staff can contact when they have concerns about child maltreatment. This pilot program was designed to build upon already strong language interpretation services by adding trained members of the OJC who could 'translate' the information that was needed and better explain our services and responsibilities in a sensitive way which would be better understood and accepted by OJC families.

In this report, we evaluated the effects of this pilot program by reviewing administrative records to determine if implementation has modified

CM reporting among cases referred to our institutional child protection committee. We also sought to determine if the effects varied by type of abuse or the age and gender of the child and whether there were measurable differences before and after the pilot was initiated.

Methods

Program Description

The hospital child protection committee is composed of physicians, nurses, social workers, and other hospital professionals who assist staff at both hospitals in reporting procedures, track patient outcomes, conduct quality assurance activities, and provide education and training for staff about child abuse and neglect in a model used by other children's hospital-based teams (National Association of Children's Hospitals and Related Institutions, 2006). Committee members may assist clinical staff, consult directly with families, and make recommendations about CM reporting, but staff are not required to follow these recommendations.

We implemented internal procedures as part of this pilot project in 2015 as part of our quality improvement efforts to improve care for this population. Using a framework that goes beyond the language interpretation services regulatorily required in healthcare facilities (Reardon, 2009), our child protection committee and patient liaison program identified "cultural interpreters" among our patient advocate staff to facilitate culturally competent communication with OJC families. These interpreters are hospital staff who function in the medical center as patient liaisons and advocates who are actual or perceived members of the OJC. Different from the "cultural elder," "cultural wayfinder," or "speaking Haredi" models, these interpreters do not treat or direct families in how or where to seek care; rather, they explain medical and hospital procedures and CM mandated reporting and reassure the family that information being provided about the injury, family members, and home environment is the standard of care needed to evaluate the

child's medical condition. When the hospital child protection committee is notified about a child with concerns of CM, the cultural interpreter is contacted to assist the family by providing needed information and helping their understanding of medical procedures. They are available in-person or by telephone, which is especially valuable during late evening or early morning hours. They also advise staff on best practices for interacting with OJC families. On-call social workers and child abuse pediatricians who have training and experience to understand these cultural issues are also contacted and can assist in CM reporting procedures.

Study Design and Analysis

In order to assess whether there were any differences in CM reporting before and after implementation, we conducted a retrospective review of administrative records from two years (2011 and 2016) and constructed a convenience sample with families who self-identified as being from the OJC. These years were chosen because they offer the most complete available administrative data regarding interactions of families with our institutional child protection committee before and after implementation. If needed, social work notes were also consulted. For this analysis, the child's age (< 5 years or ≥ 5 years), gender, primary maltreatment concern (abuse or neglect), and whether the case was reported to child protective services by our institution were collected. Rates for reporting were analyzed by child age, gender, and CM type and compared in the two study years, and chi-square and Fisher's exact tests were used as appropriate to parametrically compare proportions, with $p < 0.05$ taken as statistically significant. Abuse was defined to include physical, sexual and psychological abuse, while neglect included physical, supervisory, and medical neglect. In addition, minutes from child protection meetings for the applicable periods were reviewed and committee comments regarding any use of cultural interpreters were noted. This study was reviewed and deemed exempt from further review by our institutional research committee.

Table 1. Comparison of child and report factors before and after implementation

	2011	2016	TOTALS
Total	18	20	38
AGE			
0–4 y	13	13	26
≥5 y	5	7	12
GENDER			
Male	10	14	24
Female	8	6	14
MALTREATMENT			
Abuse	7	11	18
Neglect	11	9	20
CPS STATUS			
Reported	6	4	10
Not Reported	12	16	28

Results

A total of 38 cases meeting inclusion criteria were found, including 18 from 2011 and 20 from 2016 (see Table 1). Among cases referred to the hospital child protection committee, fewer (one-fourth) were reported to child protective services after cultural interpreters were implemented than were before (one-third). There were fewer cases of neglect referred to our committee (11/18 in 2011 vs. 9/20 in 2016) and fewer neglect reports (4/11 vs. 1/9) after implementation. The number of abuse cases rose as did the proportion that was reported. Overall, nearly two-thirds (25/38) of committee referrals were boys, and most (29/38) were younger than 5 years old. The proportion of boys being reported decreased (4/11 vs. 3/14), and a greater decrease in reporting was noted among younger children. None of the differences in proportions, however, were statistically significant.

Meeting minutes noted that committee members reported that families expressed better understanding of medical procedures and legal mandates for professionals caring for their children after implementation. Medical providers expressed more satisfaction after being able to make more complete and accurate reports when indicated. We have also noted that when these procedures could not be used (usually because of staff unavailability or lack of knowledge on how to access them), parents and staff often expressed frustration and anger about CM reporting and outcomes.

Discussion

Our preliminary experience with the use of "cultural interpreters" is promising. Not all CM reports have been avoided, however, and reports continue to be made when indicated but with more complete medical history available to facilitate investigation and provide services. There was a decrease in the proportion of referrals and reports by our hospital child protection committee for potential neglect which, if true, supports our hypothesis that reports for suspected neglect may be avoided if adequate medical information can be obtained from OJC families.

The overall proportion of cases overall reported to CPS by our hospital child protection committee and the relationship to CM type is not addressed by our study. Similar to national data, most of the children referred to our committee in this sample were young and therefore less able to disclose what had happened to them (U.S. Department of Health & Human Services, 2018). We speculate that the high proportion of boys may reflect cultural practices in the OJC in which boys are treated differently from girls by parents. Differences in family class and ethnicity have been shown to have effects on the identification and response to CM, and parents with high social status often resist the investigation and caseworkers have difficulties in defining the abuse (Aadnanes, 2017). One hospital trauma registry, for example, reported data for 697 pediatric trauma patients, of

which 87 were reported as suspected abuse victims. This was 8% of their pediatric trauma patients with a median age of 6 months, ranging from newborn to age 10 years, and most victims (55%) were male (Draus, 2017). Another prospective multi-center study of all 968 consecutive cases referred to child protection teams in six medical centers in Israel noted high rates of reporting (61.7%) among cases referred to their teams, with a child's young age and other family factors being associated with the decision to report (Benbenishty, Jedwab, Chen, et al., 2014).

Limitations

This was a single-institution study with a small number of subjects, limiting its statistical power and generalizability. Given our location in a very large metropolitan area with multiple medical centers, the lack of pediatric trauma center designation during the study period, and selective use of our pediatric services by the OJC, we suspect that our experience is not comparable to that of other centers. The mix of cases (abuse vs neglect) and community resources may impact the functions our committee is asked to accomplish, and our population and child protection committee may be unique. One survey of child protection teams noted that experts believed that effective teams should provide communication of findings to appropriate agencies (mean Likert score: 7.0), court testimony (7.0), medical consultations (6.9), multidisciplinary case review (6.6), and forensic interviews (6.0) (Kistin, Tien, Bauchner, et al., 2010). In our setting, referral and consultation are considered primary functions, with much less interviewing and court appearance needed. In addition, child sexual abuse has been reported in other Jewish communities, but we saw few cases at our institution (Rosmarin, Pirutinsky, Appel et al., 2018). Thus it is unclear whether our program of cultural interpreters would have the similar results in other settings.

There are also several limitations to procedures of this nature being used in a large, metropolitan area with diverse cultures. The OJC lives

in multiple counties and states with different child protective services agencies and reporting practices. Language may be an issue, with some members of the OJC only speaking Hebrew or Yiddish. The OJC is not homogenous, and cultural interpreters, while actual members of or perceived as members of the OJC, are not necessarily part of all these individual sects. This has been noted to be perhaps the most daunting challenge facing professionals who work with Orthodox Jews (Schnall, 2006). Safety concerns about other children in the home may not allow for any delay in reporting while the cultural interpreters are becoming involved. Individual health professionals have individual mandates under our state's reporting laws, and some choose to make reports irrespective of our institutional procedures. Lastly, while we aim to obtain the best information from families, individuals may still continue to not share information or obfuscate or obstruct an evaluation because of their perceived guilt or for other reasons. Brofsky (2017) has concluded that concerns about *mesira* and *leshon ha-ra*, however, should not stand in the way of taking proper actions to protect victims and prevent further abuse, and he has noted that there are *halakhic* sources which demand and obligate the medical community and the OJC to stop and prevent sexual, physical, and emotional abuse.

Conclusions

It appears that our program of cultural interpreters had some impact on the number of children being referred and reported for suspected neglect. We hope to extend our understanding of best practices for responding to concerns about child maltreatment in this isolated and insular community by reviewing additional evidence-informed, culturally-relevant strategies that can be adapted from other communities. We also hope to improve our current strategy through additional systematic, retrospective chart reviews comparing cases referred to our child protection committee to assess reporting rates by concern and injury type. Feedback can be sought from OJC representatives as well as directly from families receiving CM medical evaluations at our

institutions. Medical and social work staff involved in these referrals can also be contacted about procedures they used and their perceptions of the evaluation and reporting processes. This will inform further development and implementation of more effective medical care for OJC members in our health care system.

References

Aadnanes, M. (2017). Social workers' challenges in the assessment of child abuse and maltreatment: Intersections of class and ethnicity in child protection cases. *Critical and Radical Social Work, 5*(3), 335–350.

Band-Winterstein, T., & Freund, A. (2015). Is it enough to 'Speak Haredi'? Cultural sensitivity in social workers encountering Jewish Ultra-Orthodox clients in Israel. *British Journal of Social Work, 45*, 968–987.

Benbenishty, R., Jedwab, M., Chen, W., Glasser, S., Slutzky, H., Siegal, G., Lavi-Sahar, Z., & Lerner-Gevac, L. (2014). Predicting the decisions of hospital based child protection teams to report to child protective services, police and community welfare services. *Child Abuse & Neglect, 38*, 11–24.

Betancourt, J. R., Green, A. R., J. Emilio Carrillo, E., & Park, E. R. (March/April 2005). Cultural competence and health care disparities: Key perspectives and trends. *Health Affairs, 24*(2), 499–505.

Blank, S., Myers, J. E., Pathela, P., Washburn, K., Varma, J. K., Hadler, J. L., Farley, T. A., & Schillinger, J. A. (2012). Neonatal herpes simplex virus infection following Jewish ritual circumcision that included direct oral genital suction in New York City. *Mortality and Morbidity Weekly Report, 61*(22), 405–409.

Brofsky, D. (2017). Discussing and reporting abuse – a Halakhic perspective. *Tradition, 50*(2), 60–77.

Christian, C. W., & the Committee on Child Abuse and Neglect. (2015). The evaluation of suspected child physical abuse. *Pediatrics, 135*(5), e1337–e1354.

Cohen, S. M., Ukeles, J. B., & Miller, R. (2012). *Jewish Community Study of New York: 2011 Comprehensive Report*. UJA-Federation of New York, Jewish Policy & Action Research. Retrieved from http://www.ujafedny.org/jewish-community-study-of-new-york-2011

Connolly, S. (2012). Everyone's business: Developing an integrated model of care to respond to child abuse in a pediatric hospital setting. *Social Work in Health Care, 51*(1), 36–52.

Cooperman, A., & Smith, G. A. (13 October, 2013). *Eight facts about Orthodox Jews from the Pew Research Survey*. Washington, DC: Pew Research Center. Retrieved from http://www.pewresearch.org/fact-tank/2013/10/17/eight-facts-about-orthodox-jews-from-the-pew-research-survey/

Dollin, Y., & Roth, J. (2018). Psychiatric malpractice in Jewish law. *Journal of Jewish Ethics, 4*(1), 47–94.

Draus, J. M. (2017). A multidisciplinary child protection team improves care of non-accidental trauma patients. *The American Surgeon, 83*(May), 477–481.

Gallagher, P. (2009). Identification and analysis of Orthodox Jewish enclaves in Brooklyn, New York: A GIS based approach. *Middle States Geographer, 42*, 83–89.

Greenbaum, A. L. (2002). Vowing to face who we really are: Child abuse and domestic violence in the Jewish community. *Journal of Religion & Abuse, 4*(1), 69–76.

Holter, J. C., & Friedman, S. B. (1968). Child abuse: Early case finding in the emergency department. *Pediatrics, 42*, 128–138.

Hymel, K. P., & the Committee on Child Abuse and Neglect. (2006). When is lack of supervision neglect? *Pediatrics, 118*(3), 1296–1298.

Kistin, C. J., Tien, I., Bauchner, H., Parker, V., & Leventhal, J. M. (2010). Factors that influence the effectiveness of child protection teams. *Pediatrics,* 126, 94–100.

Jewish Community Health Initiative. (n.d.). Helping Jews lead healthier lives. Cleveland, OH: Author. Retrieved from http://jewhealth.org/health_conditions.aspx

Lighter-Fisher, J., Phillips, M. S., Stachel, A., Chopra, A., Rosman, I., Fisher, J. C., Li, Y., Copin, R., Rosenberg, R., & Shopsin, B. (2016). Geographic cluster of community-acquired methicillin-resistant Staphylococcus aureus infections among pediatric patients from Brooklyn, New York. Poster Abstracts *OFID IDWeek, 1*(Suppl 1), S1.

National Association of Children's Hospitals and Related Institutions. (2006). *Defining the Children's Hospital Role in Child Maltreatment*. Retrieved from http://bsfi.barnlakarforeningen.se/wp-content/uploads/sites/13/2016/03/nachri.full_.guidelines05.pdf

Palusci, V. J., & Vandervort, F. E. (2014). Universal reporting laws and child maltreatment report rates in large U.S. counties. *Children and Youth Services Review, 38*, 20–28.

Raz, M. (2017). Unintended consequences of expanded mandatory reporting laws. *Pediatrics, 139*(2), e20163511.

Reardon, C. (2009). More than words—Cultural competency in healthcare. *Social Work Today, 9*(3), 12. Retrieved from http://www.socialworktoday.com/archive/051109p12.shtml

Rosen, J. B., Arciuolo, R. J., Khawja, A. M., Fu, J., Giancotti, F. R., & Zucker, J. R. (2018, July 30). Public Health Consequences of a 2013 Measles Outbreak in New York City. *JAMA Pediatrics*. doi:10.1001/jamapediatrics.2018.1024

Rosmarin, D.H., Pirutinsky, S., Appel, M., Kaplan, T., & Pelcovitz, D. (2018). Childhood sexual abuse, mental health, and religion across the Jewish community. *Child Abuse & Neglect, 81*, 21–28.

Schick, M. (2009). A Census of Jewish Day Schools in the United States 2008–2009. New York: Avi Chai Foundation. Retrieved from http://avichai.org/wp-content/uploads/2010/06/Census-of-JDS-in-the-US-2008-09-Final.pdf

Schnall, E. (Summer 2006). Multicultural counseling and the Orthodox Jew. *Journal of Counseling & Development, 84*, 275–282.

U.S. Department of Health & Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2018). *Child maltreatment 2016*. Retrieved from https://www.acf.hhs.gov/cb/research-data-technology/statistics-research/child-maltreatment

White, S., Wastell, D., Smith, S., Hall, C., Whitaker, E., Debelle, G., Mannion, R., & Waring, J. (February 2015). Improving practice in safeguarding at the interface between hospital services and children's social care: A mixed-methods case study. *Health Services and Delivery Research, 3*(4). doi:10.3310/hsdr03040

Single Fathers in Child Welfare

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Single fathers are one of the fastest growing populations nationally, yet the focus in most child welfare research has been on the engagement of non-residential fathers. Using a microstructural framework, this essay aims to highlight the deficiencies of current research and practice by proposing the use of a phenomenological approach to better understand the lived experiences of this isolated population, with the ultimate goal of developing a comprehensive database that includes the experience of custodial fathers. Studies that give a voice to a small, albeit growing group of single parents will ultimately improve organizational and caseworker practice while simultaneously enhancing the experience of children who must endure the child welfare system.

Because of the current increase in single father-headed households— a jump from 12.5% to 17.5% in just 10 years—it is necessary to make this group of parents a priority (Grall, 2016; U.S. Census Bureau, 2017). Most research to date has focused on the engagement of non-residential fathers in the case-planning processes (Bellamy, 2009; Cahalane & Anderson, 2013), although there are some exceptions where the researchers focused on child welfare workers' attitudes toward fathers (Arroyo & Peek, 2015; Shadik & O'Connor, 2016). This is in part due to the continued negative view of fathers among child welfare professionals as well as the majority of children involved in child welfare coming from homes headed by a single mother or two parents. (Brewsaugh & Strozier, 2016; Yampolskaya, Armstrong, Strozier, & Swanke, 2017).

Literature Review

Despite the rapid growth of single fatherhood, the research and subsequent literature has not yet caught up (Coles, 2015; Shadik &

O'Connor, 2016). Among general population studies, the results tend to compare the outcomes (e.g., the parent's overall competence or the child's social and emotional development) of single fathers to single mothers (Bronte-Tinkew, Scott, & Lilja, 2010; Livingston, 2013). Early studies of the population were qualitative in nature, with a focus predominantly on recently divorced fathers who are White (Coles, 2015); since the 1990s, more quantitative approaches have been used, yet the dominant population is still fathers who are White, with little diversity in race or ethnicity (Coles, 2015; Shadik & O'Connor, 2016). Although single fathers who are White continue to make up the majority of these single parents (56%), the group is becoming far more diverse, with approximately 12% of fathers identifying as Black and 23% identifying as Latino (Eickmeyer, 2017).

To date, most child welfare literature is singularly focused. A portion of the literature is dedicated to the attainment of child support (i.e., financial acquisition; Grall, 2016), although the emphasis is mainly on custodial mothers obtaining support for their children (Huang & Han, 2012). The majority of the literature is on the engagement of non-residential fathers (Bellamy, 2009; Campbell, Howard, Rayford, & Gordon, 2015) as there is evidence of positive outcomes for children involved in child welfare when a father or father-like figure is present (Burrus, Green, Worcel, Finigan, & Furrer, 2012; Coakley, 2013b; D'Andrade, 2017; Leon, Bai, & Fuller, 2016). However, in general, the inclusion of fathers in child welfare cases, particularly foster care, remain elusive as a result of gendered stereotypes of fathers and a lack of caseworker knowledge and exposure (Brandon et al., 2009; Shireman, 2015; Zanoni, Warburton, Bussey, & McMaugh, 2013), including how child welfare social workers are taught about fathers in their educational training (Brewsaugh & Strozier, 2016). In a content analysis of textbook vignettes in child welfare classes, the researchers found the majority of cases depict the father as the perpetrator and/or the mother solely ensuring child safety when abuse did occur, thus reinforcing a bias against fathers (Brewsaugh & Strozier, 2016). At the organizational level, Coakley (2013a) found that despite fathers wanting to be

involved in the planning stages of their child welfare case, unfair policies and practices coupled with social worker's negativity hindered their involvement.

Theoretical Framework

Unlike single mothers, single fathers must endure the dichotomous pressure of behaving like a mother (e.g., invest in parenting and household work) while adhering to the macro gender norm of being "traditional men" (e.g., be the financial provider; Hook & Chalasani, 2008). In order to better understand this phenomenon, Hook and Chalasani (2008) suggest using a microstructural (or interactional) framework. This framework suggests the behaviors of single parents, in general, have high expectations, responsibilities, and demands (Nord, Brimhall, & West, 1997; Risman, 1986; Thomson, McLanahan, & Curtin, 1992). Yet for single fathers, the dual demand is virtually unattainable as the ideology of fatherhood is to be a provider first, not a caretaker (Coles, 2015). Other macro gender norms plague single fathers, particularly in child welfare, such as a perception of being violent and disinterested in participating in the system's required processes (Bellamy, 2009; Coakley et al., 2014; Coakley, 2013a). It is worth noting, however, that there is evidence to suggest child welfare agencies, in general, are beginning to recognize the value of father involvement and practice is slowly beginning to change (Saleh, 2013).

Proposed Methods

There is currently little information available that focuses on who a child was living with at time of removal or which parent (if to a single-parent home) they went to at reunification. A partial explanation for this is based on how the child welfare database systems (i.e., State Automated Child Welfare Information System [SACWIS]) are set up. Most systems track a child through the biological mother's name regardless of who the child was residing with when they were removed (Strega et al.,

2008; Crawford & Bailey, 2016). Further, with reunifications, research typically reports the outcome of a child's exit, such as with the parent or caregiver, but does not specify parent or caregiver (U.S. Department of Health and Human Services, 2016; AECF, 2011).

Given the shortage of information on custodial fathers as primary caregivers at time of removal coupled with the lack of inclusion in reunification plans (U.S. Department of Health and Human Services, 2016), the best way to initially gain an understanding of this population is with a phenomenological approach (Husserl, 1970). This approach illuminates how certain phenomena are perceived by the participants through in-depth interviews and observations (Lester, 1999). Using the microstructural framework coupled with phenomenological research techniques, a better understanding of single fathers involved with the child welfare system can be found. This will bring to the forefront the experiences of these men from their own perspective, thus challenging structural or normative assumptions of who they are and what benefits they offer to their children. It also provides the foundation for developing more in-depth tools (i.e., surveys) that can be used within the larger population.

Research Outcomes

As stated, research on fathers in child welfare is not unknown, but child welfare agencies are only beginning to enforce the inclusion of fathers in practice (Coakley et al., 2014). The experiences of single fathers navigating the child welfare system are largely unknown because most research focuses on non-residential fathers, yet given the general view of fathers involved in child welfare—even those who have taken responsibility for their children—may be held to a different standard than their female counterparts (Coles, 2015). By having a clear research agenda that first provides a voice for this population, the potential changes in child welfare practice and policy could be enormous.

At the practice level, the short-term goal of the research findings is to inform child welfare staff and administrators of the lived experiences of

a growing population as well as providing a foundation for determining trends among this group. Although custodial fathers make up a small percentage of all single parents and their percentage in child welfare is even smaller, this type of research could also influence the interactions with non-custodial fathers in a positive manner. Ideally, this research would provide evidence to administrators of the biases and stereotypes child welfare workers may have toward fathers. This awareness could help enhance caseworker training that is specific to the importance of including fathers throughout the life of a case, with an emphasis on understanding that even men who have maltreated their children in the past are still informants on that child's history. The image that men should not only bear the burden of financial provider needs to be emphasized, particularly with fathers who become the primary caregivers.

At the policy level, the long-term goal is twofold: first, the way in which SACWIS systems collect information must be updated, particularly with the current trend of including fathers in child welfare practice. This research will provide the needed evidence to further highlight this need. Second, a subsequent database outside of federal administrative mandates needs to be created where ongoing sociodemographic information as well as personal experiences (e.g., residential changes, years involved in child welfare/social services, status of co-parenting, time spent with children, education of children, etc.) can be housed. This would allow for the ability track trends between and within this population. Moreover, this could be immensely beneficial to the field because currently, researchers are forced to draw conclusions from macro surveys like the United States Census or the National Longitudinal Survey of Youth, which do not allow for details beyond current living situation (Coles, 2015).

The creation of this database would help broaden the child welfare system's focus beyond mothers. It is well known that child welfare focuses primarily on single mothers (Strega et al., 2008; Scourfield, Smail, & Butler, 2015) and work with children is largely done with the biological mothers, even when fathers express an interest in their children. Having a database that captures information about fathers, or

more so, augments the SACWIS system to have fields specific to custodial fathers, would help administrators develop policies that are specific to the needs of this isolated population. More importantly, these additions would ultimately benefit the group that is most affected by the processes within a child welfare system: the children.

References

Annie E. Casey Foundation [AECF]. (2011). *KidsCount Data Center*. Retrieved from http://datacenter.kidscount.org/

Arroyo, J., & Peek, C. W. (2015). Child welfare caseworkers' characteristics and their attitudes toward non-custodial fathers. *Child Abuse & Neglect*, *47*, 140–152.

Bellamy, J. (2008). A national study of male involvement among families in contact with the child welfare system. *Child Maltreatment, 14*(3), 255–262.

Brandon, M., Bailey, S., Belderson, P., Gardner, R., Sidebotham, P., Dodsworth, J., Warren, C., & Black, J. (2009) *Understanding Serious Case Reviews and Their Impact: A Biennial Analysis of Serious Case Reviews 2005–2007*. Norwich, UK: University of East Anglia.

Bronte-Tinkew, J., Scott, M. E., & Lilja, E. (2010). Single custodial fathers' involvement and parenting: Implications for outcomes in emerging adulthood. *Journal of Marriage and Family*, *72*(5), 1107–1127.

Burrus, S. W., Green, B. L., Worcel, S., Finigan, M., & Furrer, C. (2012). Do dads matter? Child welfare outcomes for father-identified families. *Journal of Child Custody*, *9*(3), 201–216.

Cahalane, H., & Anderson, C. M. (2013). Family engagement strategies in child welfare practice. In Cahalane H. (Ed.), *Contemporary issues in child welfare practice*. New York: Springer.

Campbell, C. A., Howard, D., Rayford, B. S., & Gordon, D. M. (2015). Fathers matter: Involving and engaging fathers in the child welfare system process. *Children and Youth Services Review*, *53*, 84–91.

Coakely, T., Shears, J., & Randolph, S. (2014). Understanding key barriers to fathers' Involvement in their children's lives. *Child & Youth Services, 35*(4), 343–364.

Coakley, T. M. (2013a). An appraisal of fathers' perspectives on fatherhood and barriers to their child welfare involvement. *Journal of Human Behavior in the Social Environment*, *23*(5), 627–639.

Coakley, T. M. (2013b). The influence of father involvement on child welfare permanency outcomes: A secondary data analysis. *Children and Youth Services Review*, *35*(1), 174–182.

Coles, R. L. (2015). Single-father families: A review of the literature. *Journal of Family Theory & Review*, *7*(2), 144–166.

D'Andrade, A. C. (2017). Does fathers' involvement in services affect mothers' likelihood of reunification with children placed in foster care? *Children and Youth Services Review*, *81*(C), 5–9.

Eickmeyer, K. J. (2017). American children's family structure: Single-parent families. *Family Profiles*, FP 17-17. Bowling Green, OH: National Center for Family and Marriage Research. Retrieved from: https://www.bgsu.edu/content/dam/BGSU/college-of-arts-and-sciences/NCFMR/documents/FP/eickmeyer-single-parent-families-fp-17-17.pdf

Grall, T. S. (2016). *Custodial mothers and fathers and their child support: 2013*. Current Population Reports. Washington, DC: U.S. Census Bureau.

Hook, J. L., & Chalasani, S. (2008). Gendered Expectations? Reconsidering Single Fathers' Child-Care Time. *Journal of Marriage and Family*, *70*(4), 978–990.

Huang, C. C., & Han, K. Q. (2012). Child Support Enforcement in the United States: Has policy made a difference? *Children and Youth Services Review*, *34*(4), 622-627

Husserl, E. (1970). *Logical investigations*. New York: Humanities Press.

Leon, S. C., Bai, G. J., & Fuller, A. K. (2016). Father involvement in child welfare: Associations with changes in externalizing behavior. *Child Abuse & Neglect*, *55*, 73–80.

Lester, S. (1999). *An introduction to phenomenological research*. Retrieved from https://www.researchgate.net/profile/Stan_Lester/publication/255647619_An_introduction_to_phenomenological_research/links/545a05e30cf2cf5164840df6.pdf

Livingston, G. (2013). *The rise of single fathers: A ninefold increase since 1960*. Washington, DC: Pew Research Center.

Mallette, J. K., Futris, T. G., & Schramm, D. G. (2017). Fostering a culture of family-centered care: Child welfare professionals' beliefs about fathers, family instability, and the value of relationship education. *Child & Family Social Work, 23*(3), 354–363.

Nord, C., Brimhall, D. A., & West, J. (1997). *Fathers' involvement in their children's schools*. Washington, DC: Office of Educational Research and Improvement, U.S. Department of Education.

Risman, B. J. (1986). Can men 'mother'? Life as a single father. *Family Relations, 35*, 95–102.

Saleh, M. F. (2013). Child welfare professionals' experiences in engaging fathers in services. *Child and Adolescent Social Work Journal*, *30*(2), 119–137.

Scourfield, J., Smail, P., & Butler, D. (2015). A systemic approach to improving the engagement of fathers in child safeguarding. *Child Abuse Review*, *24*(2), 129–139.

Shadik, J. A., & O'Connor, M. K. (2016). Fathering and Child Maltreatment: Building Theory to Enhance Treatment Interventions. *Social Work Research*, *40*(4), 1–11.

Shireman, J. (2015). *Foundations of Social Work Knowledge: Critical Issues in Child Welfare*. New York: Columbia University Press.

Strega, S., Fleet, C., Brown, L., Dominelli, L., Callahan, M., & Walmsley, C. (2008). Connecting father absence and mother blame in child welfare policies and practice. *Children and Youth Services Review, 30*(7), 705–716.

Thomson, E., McLanahan, S. S., & Curtin, R. B. (1992). Family structure, gender, and parental socialization. *Journal of Marriage and the Family, 54*, 368–378.

U.S. Department of Health and Human Services. (2016). *The AFCARS Report: Preliminary FY 2015 Estimates as of June 2016*. Washington, DC: Author. Retrieved from https://www.acf.hhs.gov/sites/default/files/cb/afcarsreport23.pdf

Walmsley, C. (2010). Fathers and the child welfare system. Paper presented at the "Research for Practice Network." British Columbia, Canada: The Federation of Community Social Services.

Yampolskaya, S., Armstrong, M. I., Strozier, A., & Swanke, J. (2017). Can the actions of child welfare case managers predict case outcomes? *Child Abuse & Neglect*, *64*, 61–70.

Zanoni, L., Warburton, W., Bussey, K., & McMaugh, A. (2013). Fathers as 'core business' in child welfare practice and research: An interdisciplinary review. *Children and Youth Services Review*, *35*(7), 1055–1070.

Unbroken Circles: Insular Communities of Grandparents Raising Grandchildren in Rural America

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Outcomes for maltreated children residing in relative placement versus foster care are generally more favorable (Winkour, Holtan, & Batchelder, 2014), and child welfare policies often support relative placement as a first line approach to out of home care. However, relative caregivers, specifically grandparents raising grandchildren may find that they are involved in complex situations, caring for children with special needs while receiving limited support or financial assistance from child welfare agencies (Kirby & Kaneda, 2002; Choi, Sprang, & Eslinger, 2016). Concerns regarding the national opioid epidemic and its impact on families throughout the country and particularly in the Appalachian region highlight some unique challenges to service provision with grandfamilies. Discussion of this insular population and potential reasons for underrepresentation supports the development of strategies for more effective research, practice and policy in child welfare.

Target Population

In recent years, the number of grandparents acting as primary caregivers for their grandchildren has steadily increased. In the United States, 42% of grandparents residing with their grandchildren function as the primary caregiver, and the southeastern sector of the

country has the highest density of grandparents acting as head of household (U.S. Census, 2008, 2013, 2014). In Central Appalachia, significantly higher rates of custodial grandparenting have been observed compared to other parts of the country (Phillips & Alexander-Eitzman, 2016). This region also contains the highest concentration of economically distressed counties, where poverty rates can be twice the national average (Appalachian Regional Commission, 2008). These statistics parallel emerging reports of increases in the number of children entering foster and relative care in areas affected by the growing opioid epidemic including rural western, southern and Appalachian regions of the United States (Appalachian Regional Commission, 2008; McDonald, Carlson, & Izrael, 2012). Currently, some states are reporting up to a six-fold increase in the number of Neonatal Abstinence Syndrome cases, which is taxing medical, child welfare and mental health and substance abuse treatment systems (Franca, Mustafa, & McManus, 2016). If these trends continue, all systems will require additional support.

It appears that grandfamilies in rural or Appalachian communities may represent an insular group potentially underserved by child welfare. Rural and Appalachian cultures are often characterized by a strong sense of familialism and reliance on the family unit as the "circle that can't be broken" to manage times of personal crisis (Barron, 1977; Beaver, 1986; Coyne, Demian-Popescu, & Friend, 2006). However, it may be that this source of resilience in combination with geographic isolation and limited resources presents challenges to service systems in terms of identifying need.

In one study (Sprang et al., 2014) it was found that grandparents raising grandchildren in Appalachia were significantly more likely to be caring for children with special mental health or medical needs, than other grandparents, and to be in the primary caregiving role due to parental substance abuse or parental incarceration. In spite of these more complex challenges, there were no significant differences in rates of child welfare involvement when compared to their non-Appalachian counterparts. Findings from this study depict a group of children affected by trauma and adversity along with their caregivers, who may

not be receiving necessary supports. In fact, 72% of the children from both Appalachian and non-Appalachian areas had experienced at least one traumatic exposure, which was found to indirectly affect levels of grandparenting stress (Sprang et al., 2014). This suggests the insular community of Appalachian grandfamilies is not underserved by child welfare because maltreatment occurs less frequently, in fact this group seems to have higher levels of trauma and caregiving concerns. Further, grandparents from the Appalachian region were experiencing other challenges- they were significantly more likely to rely on Medicaid as their primary form of insurance, more likely to be unemployed, less educated, and more likely to be single than other grandparents.

Theoretical Framework Linking Isolation to Underrepresentation

Researchers and theorists have noted that grandparent caregiving has played a critical role in human evolution as a significant resource for adaptation and even survival of familial genes (Dolbin-MacNab & Yancura, 2017; Flinn, 2011). To understand the specific nature of this adaptation process among Appalachian families, application of ecological and contextual models is useful. According to ecological systems theory (Bronfenbrenner, 1979), families represent a prominent microsystem individuals rely upon when coping with challenging conditions, yet they are also nested within the larger systemic context that shapes the nature of these adaptations. Bronfenbrenner (1979) underscores the influence of history, culture and context in shaping the interactions, within and between the multiple layers of systems relevant to an individual's life (Darling, 2007). In Appalachia, these three factors are inextricably linked given that it is an area that has historically been challenged by significant deprivation, hardship and marginalization.

Discussions of traditional Appalachian culture include reliance on close kinship networks and familialism, strong ties to place and community, modesty, religiosity, fatalism, mistrust of outsiders and government systems and a tradition of self-sufficiency (Beaver, 1986; Helton, 1995;

Keefe, 1986; Tatum, 1994). These values or traits have been described in part as creative means of adapting to conditions of deprivation and isolation (Billings, 1974; Peters & Peterson, 1988). For example, familialism and self-sufficiency serve as critical adaptations when there are fewer community resources to utilize, and historical events have proven that in some circumstances outsiders cannot be trusted. Recognition of the adaptive function of these qualities is necessary to prevent potential helpers from pathologizing certain behaviors exhibited by Appalachians (Tatum, 1994). However, these cultural values along with geographic isolation, limited transportation, limited resources in low population density areas, and concerns about privacy and social stigma likely contribute to this being an underserved population (Coyne et al., 2006; Crowther, Ford, & Peterson, 2014; Robinson, Kropf, & Myers, 2000).

Proposed Research Methodology

Research can play a key role in helping us better understand the experiences of Appalachian grandfamilies affected by trauma and adversity. Partnering with "trusted messengers" within communities, such as faith-based leaders, school personnel, or agency leaders, can help increase community engagement, foster communication about project goals and outcomes, and build trust. There is research to suggest that familiar interpersonal relationships between knowledge messengers and receivers can positively impact how communication is evaluated (Macrae & Bodenhausen, 2000; Hewstone, Rubin, & Willis, 2002). This strategy has been used successfully in this area in the recruitment and enrollment stages of research design (Sprang et al., 2014; Schoenberg et al., 2009).

The use of respondent driven sampling (RDS) methods is also recommended to help recruit Appalachian grandfamilies for study participation. RDS utilizes link-tracing designs to reach hidden or more isolated groups through the use of incremental waves of peer recruitment (Heckathorn, 1997, Heckathorn, & Cameron, 2017). Such strategies

have been successfully used to study other isolated groups, including individuals affected by HIV and homelessness (Salazar et al., 2007), men who have sex with men (MSM; Mizuno et al., 2012) and substance users (Tucker, Cheong, Chandler, Carwford, & Simpson, 2016), including opioid users in Appalachia (Hall, Leukefeld, & Havens, 2013). The growing theoretical base for RDS (Heckathorn, 2002), its practicality in recruiting study participants, and the successful funding of projects using this sampling method by organizations such as the National Institute of Health (NIH), make it a viable sampling strategy for studying Appalachian grandfamilies.

In order to better understand the needs of grandfamilies with trauma exposed or maltreated children, variables that serve to potentially moderate outcomes need to be examined. Suggested moderating variables include potential risk factors (e.g., type of trauma exposure, trauma severity, substance use, availability of specialized mental health services), and variables that may serve as protective and/or promotive factors for these families (e.g., styles of coping, problem-solving and decision-making; attitudes toward family and qualities of attachment relationships). Previous researchers have noted that Appalachians may express their distress utilizing unique, and culturally specific terminology, and it is recommended that different contextual variables should be considered when analyzing family norms, roles and responsibilities (Keefe, 1988; McInnis-Dittrich, 1997; Van Schaik, 1988). Research methodologies should also utilize quantitative and qualitative research methods, preferably in tandem. Multi-method techniques that extend beyond quantitative measurement that may not be culturally or linguistically sensitive can help researchers contextualize findings in a way that reveals the nuances of Appalachian family life, yet avoids pathologizing family traditions. The use of focus groups to inform the research process would be helpful in gaining a richer understanding of the needs of Appalachian grandfamilies, providing cultural context to findings, identifying other trusted messengers in the community, and informing measurement activities such as survey development.

Policy and Practice Implications

This paper used grandparents raising grandchildren in Appalachia as a case example for analysis, however this discussion is relevant to service provision with grandfamilies in other insular environments. A key consideration in designing service delivery systems for these communities is to harness the social capital (e.g., sense of belonging, extended family availability) inherent in these family units towards the development of self-monitoring, self-correction, and recovery. Universal training approaches that empower a community of grandparents by enhancing their skills and capacity to act as resources within the family and community can enhance the protection provided by grandparents, while respecting their need for independence. Community wide training of grandparent groups in a trauma-informed parenting curriculum like the National Child Traumatic Stress Network's (NCTSN), *Caring for Children Who Have Experienced Trauma Curriculum,* is an example of one such approach that can be used with custodial grandparents, inside or outside of the child welfare system. This educational program would increase the grandparent's ability to detect trauma exposure and traumatic stress symptoms, advocate for and assess service options, and is culturally congruent with the socio-familial norms of these communities. In this way, custodial grandparents become partners with child welfare, versus only clients or service recipients, a relationship that is collaborative, non-hierarchical, and consistent with a trauma responsive service delivery approach that is warranted based on the experiences of children in grandparent custody.

It is important to remember however, that such partnerships should be financially viable to be reasonable. It is estimated that grandparents raising grandchildren have saved U.S. taxpayers an estimated 4 billion dollars by preventing entry of these children into foster care (Generations United, 2014; Phillips et al., 2016). Yet, investments in federally-subsidized, preventative, guardianship programs are lacking, and the absence of financial support does little to incentivize insular groups into child welfare prevention programs or partnerships. All financially

needy grandparent caregivers, functioning outside of the foster care system, should be eligible to receive financial support for their efforts. Currently, funding for kinship care and associated supports is only available in certain areas of the country, and is not yet widely available in Central Appalachia. Full implementation of this policy would have a positive, twofold effect. The state-local connections created through provision of such kinship service programs can be used as a conduit for training and support to individuals who would otherwise be reluctant to engage with child welfare, and as a voluntary policy, it respects the family traditions that create cohesion and strength in rural communities.

References

Appalachian Regional Commission. (2008). An analysis of mental health and substance abuse disparities and access to treatment services in the Appalachian region. Retrieved from https://www.arc.gov/assets/research_reports/AnalysisofMentalHealthandSubstanceAbuseDisparities10appendix.pdf

Appalachian Regional Commission. (2015). The Appalachian region: A data overview from the 2009-2013 American Community Survey. Retrieved from https://www.arc.gov/research/researchreportdetails.asp?REPORT_ID=114

Barron, H. S. (1977). A case for Appalachian demographic history. *Appalachian Journal*, *4*(3/4), 208–215.

Beaver, P. D. (1986). *Rural community in the Appalachian South.* Lexington, KY: University of Kentucky Press.

Billings, D. (1974). Culture and poverty in Appalachia: A theoretical discussion and empirical analysis. *Social Forces*, *53*(2), 315–323.

Bronfenbrenner, U. (1979). *The ecology of human development: Experiments by nature and design.* Cambridge, MA: Harvard University Press.

Choi, M., Sprang, G., & Eslinger, J. G. (2016). Grandparents raising grandchildren: A synthetic review and theoretical model for interventions. *Family & Community Health*, *39*(2), 120–128.

Coyne, C. A., Demian-Popescu, C., & Friend, D. (2006). Social and cultural factors influencing health in Southern West Virginia: A qualitative study. *Preventing Chronic Disease*, *3*(4).

Crowther, M. R., Ford, C. D., & Peterson, T. (2014). A qualitative examination of barriers for urban and rural custodial grandparents. *Journal of Intergenerational Relationships*, *12*(3), 241–256.

Darling, N. (2007). Ecological systems theory: The person in the center of the circles. *Research in Human Development*, *4*(3–4), 203–217.

Dolbin-MacNab, M. L., & Yancura, L. A. (2017). International perspectives on grandparents raising grandchildren: Contextual considerations for advancing global discourse. *The International Journal of Aging and Human Development*, 0091415016689565.

Flinn, M. V. (2011). Evolutionary anthropology of the human family. Oxford Handbook of Evolutionary Family Psychology, 12–32.

França, U. L., Mustafa, S., & McManus, M. L. (2016). The growing burden of neonatal opiate exposure on children and family services in Massachusetts. *Child Maltreatment*, *21*(1), 80–84.

Generations United. (2014). *The state of grandfamilies in America: 2014*. Washington, DC: Author.

Hall, M. T., Leukefeld, C. G., & Havens, J. R. (2013). Factors associated with high-frequency illicit methadone use among rural Appalachian drug users. *The American Journal of Drug and Alcohol Abuse, 39(4),* 241–246. doi: 10.3109/00952990.2013.805761

Heckathorn, D. D., & Cameron, C. J. (2017). Network sampling: From snowball and multiplicity to respondent-driven sampling. *Annual Review of Sociology, 43,* 101–109.

Heckathorn, D. D. (1997). Respondent-driven sampling: A new approach to the study of hidden populations. *Social Problems, 44,* 174–199.

Heckathorn, D. D. (2002). Respondent-driven sampling II: Deriving valid population estimates from chain-referral samples of hidden populations. *Social Problems, 49,* 11–34.

Helton, L. R. (1995). Intervention with Appalachians: Strategies for a culturally specific practice. *Journal of Cultural Diversity*, *2*(1), 20–26.

Hewstone, M., Rubin, M., & Willis, H. (2002). Intergroup bias. *Annual Review of Psychology, 53,* 575–604.

Keefe, S. E. (Ed.) (1988). *Appalachian mental health*. Lexington, KY: The University of Kentucky Press.

Kirby, J. B., & Kaneda, T. (2002). Health insurance and family structure: The case of adolescents in skipped-generation families. *Medical Care Research and Review*, *59*(2), 146–165.

Macrae, C. N., & Bodenhausen, G. V. (2000). Social cognition: Thinking categorically about others. *Annual Review of Psychology, 51,* 93–120.

McDonald, D. C., Carlson, K., & Izrael, D. (2012). Geographic variation in opioid prescribing in the U.S. *The Journal of Pain*, *13*(10), 988–996.

McInnis-Dittrich, K. (1997). An empowerment-oriented mental health intervention with elderly Appalachian women: The women's club. *Journal of Women & Aging*, *9*(1-2), 91–105.

Mizuno, Y., Borkowf, C., Millett, G. A., Bingham, T., Ayala, G., & Steuve, A. (2011). Homophobia and racism experienced by Latino men who have sex with men in the United States: Correlates of exposure and associations with HIV risk behaviors. *Springer Science+Business Media, 16*, 724–735. doi: 10.1007/s-011-9967-1

Peters, D. F., & Peterson, G. W. (1988). Adaptive socialization values of low-income Appalachian mothers. *Appalachian Mental Health*, 51–65.

Phillips, D. L., & Alexander-Eitzman, B. (2016). Intersections of poverty, geography, and custodial grandparent caregiving in Appalachia. *GrandFamilies: The Contemporary Journal of Research, Practice and Policy*, *3*(1), 3.

Robinson, M. M., Kropf, N. P., & Myers, L. L. (2000). Grandparents raising grandchildren in rural communities. *Journal of Mental health and Aging*, *6*(4), 353–366.

Salazar, L. F., Crosby, R. A., Holtgrave, D. R., Head, S., Hadsock, B., Todd, J., & Shouse, L. R. (2007). Homelessness and HIV-associated risk behavior among African American men who inject drugs and reside in the urban south of the United States. *Springer Science+Business Media,* S70–S77. doi: 10.1007/s10461-007-9239-2

Schoenberg, N. E., Hatcher, J., Dignan, M. B., Shelton, B., Wright, S., & Dollarhide, K. F. (2009). Faith moves mountains: An Appalachian cervical cancer prevention program. *American Journal of Health Behavior, 33*(6), 627–638.

Sprang, G., Choi, M., Eslinger, J., Whitt-Woosley, A., & Looff, R. (2014). *Grandparents as parents: Investigating the health and well-being of trauma-exposed families.* Lexington, KY: University of Kentucky Center on Trauma and Children.

Sprang, G., Choi, M., Eslinger, J. G., & Whitt-Woosley, A. L. (2015). The pathway to grandparenting stress: Trauma, relational conflict, and emotional well-being. *Aging & Mental Health, 19*(4), 315–324.

Sprang, G., Staton-Tindall, M., Gustman, B., Freer, B., Clark, J. J., Dye, H., & Sprang, K. (2013). The impact of trauma exposure on parenting stress in rural America. *Journal of Child and Adolescent Trauma, 6,* 287–300.

Tatum, T. (1994). Rural women's recovery program and women's outreach: Serving rural Appalachian women and families in Ohio. *Center for Substance Abuse Treatment, ed. Treating Alcohol and Other Drug Abusers in Rural and Frontier Areas. Technical Assistance Publication Series*, *17*, 13–20.

Tucker, J. A., Cheong, J., Chandler, S. D., Crawford, S. M., & Simpson, C. (2015). Social networks and substance use among at-risk emerging adults living in disadvantaged urban areas in the southern United States: A cross-sectional naturalistic study. *Society for the Study of Addiction,* 110, 1524–1532. doi: 10.1111/add.1301

U.S. Census Bureau. (2008). *American community survey: 2005-2007 three year summary file* [Data]. Washington, DC: Author.

U.S. Census Bureau. (2013). *B10051: Grandparents living with own grandchildren under 18 years in households. 2009-2013 American Community Survey Five Year Estimates*. Washington, DC: Author. Retrieved from https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=bkmk

U.S. Census Bureau. (2014). *American community survey: 2011-2013 three year summary file* [Data]. Washington, DC: Author.

Van Schaik, E. (1988). The social context of "nerves" in eastern Kentucky. *Appalachian Mental Health*, 81-100.

Waldrop, D. P., & Gress, C. (2003). Public assistance employees' perceptions of older adults and caregivers who apply for benefits. *Gerontology & Geriatrics Education*, *23*(1), 73–91.

Winokur, M., Holtan, A., & Valentine, D. (2009). *Kinship care for the safety, permanency, and well-being of children removed from the home for maltreatment*. Oslo, Norway: Campbell Collaboration.