



A Stronger Foundation for America's Families

Transition 2021



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Introduction

The Child Welfare League of America (CWLA) is pleased to submit *A Stronger Foundation for America's Families* to President-Elect Joseph R. Biden and the incoming 117th Congress. During this transition, CWLA offers policymakers a vision and recommendations that address both legislative and administrative efforts to improve child welfare services and, ultimately, advance the well-being of the country's families and children.

As we state in the Child Welfare League of America's National Blueprint¹ for Excellence in Child Welfare: *we envision all children will grow up safely, in loving families and supportive communities, with everything they need to flourish—and with connections to their culture, ethnicity, race, and language.*

We *value* children, youth, families, and communities. We *believe in* integrity, fairness, social justice, dignity, and honesty. We *value* these actions, qualities, and characteristics: respect, innovation, service, inclusiveness, collaboration, trust, flexibility, competence, and humility.

This nation begins 2021 under two dark shadows of the COVID-19 coronavirus, the worst pandemic in over a century, and the resulting deep recession. The pandemic has combined with a second crisis, the events following the deaths of Ahmaud Arbery, George Floyd and so many other black victims, have forced policymakers at all levels along with millions of Americans to recognize the undeniable: more than 50 years after the 1964 Civil Rights Act, there are continuing deep racial inequities and injustices that are far too common in our culture, policies, practices, law enforcement and governance. These two great crises have one key difference: we could not fully control the first one since it was disease-born, but we can control the second because it is man-made.

This can be an opportunity if we recognize the need to change. And then, *change*. We believe Americans have the creativity, expertise, and perseverance to address these challenges, especially as new and more diverse generations seek to reach this country's full and ultimate potential and achieve the great American dream with Liberty and Justice for *all* people.

This *A Stronger Foundation for America's Families* reflects the collective wisdom, insights, and concerns of CWLA's public and private member agencies. These agencies, small and large, provide an array of child welfare and related services to vulnerable children, youth, and families in cities and communities across all 50 states. This document is based on a review of our CWLA National Blueprint, policies, best practice guidance, and advocacy positions researched and crafted over the past several years.

In 2009 we issued a transition paper for the new Administration in the months immediately after the passage of the Fostering Connections to Success and Increasing Adoptions Act of 2008 (Fostering Connections Act, P.L. 110-351).² We are still awaiting the full implementation and benefits of that legislation and need to achieve greater progress. Today, in 2021, we are making a new set of recommendations after passage of another significant child welfare act, the 2018 Family First Prevention Services Act (P.L. 115-123)³ which was in the early stages of implementation when the pandemic hit in early 2020.

These most significant changes, and several other smaller ones enacted over the past decade have a long way to go before we fully realize a greater and more significant reduction in out-of-home placements, and better outcomes for children and families. We believe you cannot address the complex challenges within child welfare by merely moving the same federal dollars around from one part of child welfare to another, it will take genuine investment of new federal dollars—especially in primary prevention. That said there is something even more critical: this will require an expanded effort that reaches beyond “child welfare,” and includes other national challenges including the need to reduce poverty significantly and permanently, especially child poverty.

The actions of policymakers at the start of this third decade must operate now more than ever before to a rededication and commitment to focus on the disproportionate or overrepresentation of minority populations in child welfare. To do that we must go beyond slogans and hashtags and commit dollars and actions. We need to address primary prevention and we need to fully develop the intervention and secondary prevention services part of the Family First Act so that these services can become a reality. We need to build more completely on the tools created in the 2008 Fostering Connections to Success law by utilizing to the maximum extent possible the use of kinship care, extended care for youth in out-of-home placements, more effective education practices, health care oversight and better guaranteeing the rights of children and families that do come into contact with the state child welfare systems. The Family First Act offers, for the first time, the potential of federal funding to strengthen families that have been reunified and to support families that have adopted from foster care and are later faced with challenges.

In the provision of all these services we must rededicate ourselves to making sure all services are available equitably and without prejudice, to all communities regardless of color, race, or native heritage.

We must now expand on the health care reforms of the Affordable Care Act and finally live up to our commitment from 1963 with the enactment of the Community Mental Health Act of 1963 (CMHA) (also known as the Community Mental Health Centers Construction Act, Mental Retardation Facilities and Construction Act, Public Law 88-164)⁴ to provide community mental health centers and services as a replacement for the institutionalization of patients in need of mental health care services.

Just as the great recession of 2009 limited the immediate promise of the 2008 Fostering Connections Act, so does the recession of 2020 limit the immediate promise of the 2018 Family First Act. As a result, many if not all states are or will be considering significant budget cuts. In the coming weeks, assessing how human services can be protected from budget cuts, at the very time when human need will increase, will be critical. This recession as well as the pandemic will almost certainly extend challenges for families, especially those at the lowest rung of the economic ladder. The pandemic highlights the disproportionate effect of both the COVID-19 virus and the recession on communities and families of color. At a time when human services agencies, both public and private will be in greater demand for support, state and local budget cuts will challenge state and local agencies in many ways. We must shape federal policy over the next year in a way that takes this into account and attempts to address these inequities and past failings of federal and state policies.

Despite these challenges, we offer this document as a detailed blueprint that, carried out over both the short and long term, can create a strong vision for this country’s most vulnerable children and families—and all of America’s families. CWLA envisions a future in which families, communities, organizations, and governments ensure all children and youth benefit from the resources they need to grow into healthy, contributing members of society. Child welfare services must be available to families whenever concerns arise about the safety and well-being of children, but those services must be part of a much more significant effort to strengthen families through a range of policies and services that are not “child welfare.” These services must include an effort to cut child poverty, strengthen and improve access to health care and break down racial, ethnic, and native barriers.

CWLA's model embraces the principle that families must be at the center of services that prevent and remedy situations that lead to child abuse and neglect. The full spectrum of services for children and families must be unrestricted, from the first awareness a family is at risk, to early intervention, to foster care for those children whose safety and well-being is threatened, through permanency and the services necessary to sustain permanency. Ensuring quality casework practice, according to national child welfare standards, requires a professional workforce. Recruiting, hiring, training, and retaining qualified, culturally diverse, and competent, effective, and dedicated professionals is essential to this effort.

In this transition paper, we offer short- and long-term recommendations across eight key areas. The short-term recommendations address matters to be addressed quickly by changes in federal policy, guidance, or regulation. Many of these short-term proposals relate to the new Family First Prevention Services Act and the predecessor Fostering Connections Act and how it is implemented and regulated. The long-term recommendations will require greater effort, and, in all likelihood, legislation worked out cooperatively between the new Administration and the 117th Congress. The eight global areas of child welfare we address:

Equality & Inclusion: Racism, Disproportionality, Discrimination

Preventing Child Abuse and Neglect

Strengthening Families and Children Through Secondary Prevention and Intervention Services

Permanency for Children and Families Through Foster Care Reunification, Kinship Care, and Adoption

Helping Young People

The Fundamental Building Blocks of a Successful System for Children and Families: Workforce

The Health of Children and Families

Immigration Issues

CHAPTER 1: Equality & Inclusion: Racism, Disproportionality, Discrimination

Disproportionality in child welfare refers to the over-or under-representation of a particular ethnic or racial group within the child welfare system, compared with their respective percentage in the general population. An early 1980 HHS National Incidence Study showed that all children, regardless of race or ethnicity, are equally likely to be abused or neglected. But in the years following the study, minorities, especially African American children, were overrepresented within the child welfare population at various stages.

At the end of the last century, 1999 and shortly after the Adoption and Safe Families Act (PL105-89) took effect, the number of children in out-of-home (foster) care reached an all-time high of 564,000 children.⁵ Of this total, 38 percent of the children and youth in foster care were black while 34 percent were white, and 17 percent were Hispanic. Not only was that an overrepresentation of the black population in foster care, but the actual number of black children and youth at 214,000 exceeded the number of white children in care at 191,000.⁶

The percentage of black children in foster care decreased to 30 percent in 2009⁷ and to 23 percent by 2019.⁸ This represents a significant decrease in the percentage and number of black children in foster care but still a disproportionate percentage of black children when you consider 14 percent of the child population is black. As is the case in any national review of data on child welfare, a state-by-state review can provide a very different picture and that is the case here. Some states have a much higher and disproportionate share greater than these numbers. In regard to the Hispanic population, national AFCARS data indicate that 20 percent of the child population was Hispanic in 2009 compared to 21 percent in 2019. That compares to a Hispanic child population of 25 percent in 2019.⁹ American Indian/Alaska Native remained the same between the three time periods at 2 percent. The national data on Native American children is not as detailed and in several instances some jurisdictions have a significant Native American population, and it deserves a closer look in these jurisdictions. The 2018 outcomes report data shows that in 17 states the percentage of black children in foster care was more than two times the percentage black children in those states.¹⁰

Data on substantiated cases of child maltreatment in 2018 indicate that of the 3,960,823 total referrals for child abuse and neglect, 2,402,827 of these children were referred for further investigation. That investigation process resulted in 677,529 substantiated child victims of maltreatment, with 21 percent of these child victims being African American children.¹¹

The COVID-19 pandemic has focused greater attention on racial inequality across this country and across systems and services. Early data released in June 2020 by the Centers for Disease Control and Prevention (CDC) demonstrated real problems. CDC released data¹² that examined the hospitalizations due to having the coronavirus and it showed that when the data was broken out by racial and ethnic impact as well as the impact on patients with underlying health risks there was a disproportionate impact. Among 599,636 (45%) hospitalization cases with known information, 33% of persons were Hispanic or Latino of any race (Hispanic), 22% were non-Hispanic black (black), and 1.3% were non-Hispanic American Indian or Alaska Native (AI/AN). These same inequities show up in COVID-19 related statistics regarding the economy,

access to vital human services including public health, health care, education, and access to housing.

As such, any comprehensive approach to addressing racial equity injustices requires actions outside of child welfare as well as corrections within this area of human services. So, any changes advocated here can contribute to solving the problem of disproportionality or racial inequity. A more complete response requires changes beyond child welfare. Anyone looking for changes to the primary child welfare laws including Title IV-B and Title IV-E of the Social Security Act or other federal laws including the Child Abuse Prevention and Treatment Act (CAPTA) as the only solution will fall short.

The solutions include everything in this document as well as many others including how we deal with poverty, income inequality, access to equal and fair housing, quality education and early childhood education and care, and health care.

Within child welfare and child protection policy, several steps can help to address overrepresentation of racial and ethnic populations.

Some data shows that once the decision is made to investigate, race and ethnicity are no longer factors in determining maltreatment, which is contrary to other data that contends race *is* a factor throughout a child's stay within the child welfare system. Furthermore, disproportionality is found in the type of services provided. Although African American and Native American children are more likely to be removed from their families and placed in foster care, white children and their families are more likely to receive in-home services.¹³

There are several instances within child welfare where we can make improvements in how we help families. Part of the solution is based on history; we need to follow through on policies and ideas that have been suggested before. We can use the Child Abuse Prevention and Treatment Act to improve practice and strengthen primary prevention. CAPTA has the word "prevention" embedded in its title since its creation in 1974. Congress needs to provide enough funding to make improvements in how we interact with families while protecting children in those instances when a child's safety and well-being are threatened.

The first step is to review past actions and legislative initiatives where there was not proper follow-through. The United States Senate HELP Committee report written in 2010 on the reauthorization of CAPTA provided a critical history of parts of CAPTA and prevention initiatives that we need to build on 10 years later:¹⁴

"In 1990, the Family Resource and Support Centers Program was established (by Public Law 101-501) to fund States, on a competitive basis, to establish statewide networks of family support programs, in collaboration with existing health, mental health, education, employment and training, child welfare, and other social services agencies within the State. HHS awarded three grants of \$1.5 million each to Maryland, Virginia, and Connecticut.

Each State took a unique approach to the operation of this program. One administered it through the State Health Department, another through the State Education Department, and the third through a private nonprofit entity.

Programs established under this authority were designed to operate consistent with the family support philosophy: the basic relationship between programs and the family is one of equality and respect; participants are a vital resource; programs are community-based and culturally and socially relevant to the families they serve; parent education, information about human development, and skill building for parents are essential elements of every program; and programs are voluntary.

The collaborative efforts of these programs resulted in critical innovations at the State level. These efforts also strengthened existing comprehensive programs in communities and tested innovative approaches at the local level. Services provided included parent education, early childhood development, outreach, community and social services referrals, housing assistance, job training, and parenting support, all of which help prevent child abuse.

The 1996 amendments to CAPTA rewrote Title II of the act and renamed it the Community-Based Family Resource and Support Grants...

The history of what is now referred to as CB-CAP has been one of stagnant and dismal funding. Between 2004 and 2019, the program was funded at approximately \$39 million a year in a federal budget that exceeded \$4.1 trillion before the pandemic. Funding was finally increased to \$55 million in 2020. Perhaps as sign that policymakers are now recognizing the need for greater funding for community-based support, the House of Representatives COVID-19 relief package adopted on May 15, 2020 proposed to go further with funding increases in recognizing that the pandemic and the recession have created unnecessary crises for families meaning that we must provide much greater support for these community-based family supports.

An additional area of past focus through CAPTA was on how families are approached by the child protective services system (CPS). Due to school closures and the isolation that the 2020 pandemic has created, there have been numerous stories and reports that child abuse reports are down due to school closures. At the same time, there were concerns about how families were struggling with the stresses of isolation, economic hardship, and lack of support in a number of areas of need. Some have suggested that because the majority of reports and substantiated cases of child maltreatment are categorized as neglect, there needs to be an alternate response to reports. In fact, we need to avoid sweeping and simplistic conclusions or solutions (a majority of child fatalities are reported as caused by neglect)¹⁵ but it is clear that we need a stronger family-based response to child protective services. This is not a new approach or idea but one that has been debated for several years.

Once again, we are reminded that there are or areas of human services that are contributing to many neglect reports and concerns. The inability to find or maintain adequate housing, income support especially when the economy turns down as it has in 2020, adequate nutrition and many poverty-related problems raise concerns during the pandemic as well as other times. If we could be addressing these needs in the first place, that would be “prevention.”

The same 2010 Senate HELP Committee report on the CAPTA reauthorization outlined the core elements of an “alternate track” or “differential response” system which attempts to service families in a different way:

“Differential response is a State or community-determined formal response that assesses the needs of the child or family without requiring a determination of risk or occurrence of maltreatment. Such response occurs in addition to the traditional investigatory response.”

Based on research through a federally funded Quality Improvement Center (QIC) a differential response system as including eight distinct elements:

- (1) the use of two or more discrete responses to reports of maltreatment that are screened in and accepted by the child protection agency for response.*
- (2) pathway assignment determined by a variety of factors that may include presence of imminent danger, level of risk, the number of previous reports, among others;*
- (3) pathway assignment is flexible and can be changed with additional information;*
- (4) ability of families who receive a non-investigatory response to accept or refuse to participate in differential response;*
- (5) voluntary services for families who receive a non-investigatory response, as long as safety of child is not compromised;*
- (6) establishment of discrete responses is codified in State statute, protocols, and policies;*
- (7) no formal determination, such as substantiation or finding of abuse or neglect, that child maltreatment has occurred is necessary for differential response; and*
- (8) a differential use of the central registry, depending on the type of response so that there is no identification of individuals served through a non-investigation family assessment.*

There is debate over the various approaches states have used as ‘differential response’ with some states using a diversion system of referral that does not necessarily include support and help in accessing needed services but merely diverts to another agency such as TANF. Other states have created a service and social work model that works with families to help them access and address issues that led to reports. The more important point is that some have raised up the need to have a system that does allow an alternate approach to helping families that are not instances of abuse whereby the child is not in an unsafe circumstance.

We need to review what we have learned and commit additional support and research for genuine efforts to provide a safe alternative in appropriate cases. In addition to these past proposals, we also need to review some recent recommendations and practice from other reports and studies. One such report is the Commission to Eliminate Child Abuse and Neglect Fatalities. That Commission¹⁶ examined disproportionality of child protection. They made several recommendations to “ensure that quality services are available to our children and families and that all families are treated equitably.”

Some of these recommendations included federal guidance and policies to promote agency self-assessment and worker training to address racial equity; new tools to assess racial equity and disproportionality in child welfare; incorporation into the Child and Family Services Reviews an indicator of the degree to which racial disproportionality is found within various aspects of a

state's child welfare system; the promotion of workforce training where needed; and focused research on implicit biases impact assessment, access to services, and service delivery.

We also need to focus more attention on how to better use internal and external data that can help inform and examine community conditions that can allow for a targeted approach to addressing inequities. We need to include and encourage cross system sharing of data and leverage information.

Relative caregiving

In addition to points of entry and exit, type of placement is significant in comparing lengths of stay among racial and ethnic groups. African American and Hispanic children are more likely to be placed with relatives (32% and 48% respectively), than are White children (27%).¹⁷ In past studies such as reports to Congress by the GAO, testimony before Congress, and other research suggests that kinship care is an important tool to reduce the overrepresentation of children in foster care.

Congress took some important steps in 2008 to offer tools to state and private agencies to address the challenge of disproportionality. GAO had urged Congress to enact new laws to extend the use of Title IV-E funds to kinship placements. Under the Fostering Connection to Success Act, (PL 110-351) Title IV-E funds became available for kinship placements. The 2008 law also allows tribal governments and communities to apply directly for Title IV-E funds to provide foster care, adoption subsidies, and kinship care. Twelve years after that law was passed, approximately 12 states still have not expanded services in this way through federal title IV-E funding.¹⁸

A new GAO report issued in July 2020, Child Welfare and Aging Programs, found that the Title IV-E subsidized guardianships state option under Title IV-E has been taken up by 33 states with an additional three states (Arkansas, North Carolina, and Oklahoma) having taken the option, but they were not serving families in 2019.¹⁹

For that placement to be covered by federal Title IV-E funding, the 2008 law included a threshold that requires a child to be at least 6 consecutive months in the home of the prospective relative guardian in formal foster care and eligible for IV-E funding before they transition to a subsidized guardianship. This requirement is in addition to protections including that the child has a strong attachment to the relative guardian and the relative caregiver has a strong commitment to caring permanently for the child and a requirement that a child 14 years of age or older is consulted on the placement. Relative subsidized guardianship is still linked (like foster care) to the 1996 AFDC eligibility standard.

The six-month requirement was included more as cost saving measure to enable the passage of the legislation and not a protection for the family. As a result, twelve years later there are only 38,000 children in permanent subsidized guardianships. That compares to more than 514,000 adoption assistance claims.²⁰ In 2019 at least 13,000 children were in formal foster care with a plan to live with a relative and 133,000 children in formal foster care were in relative foster care.²¹

Adoption has also been a part of the discussion on racial equity over many years. Currently (2019) there are 122,218 children waiting to be adopted. Of this population 44 percent are white children, 22 percent are black children and 22 percent are Hispanic. Like the foster care numbers, these figures are an improvement over the past ten years but like those numbers, additional improvement is needed. Of the 66,000 children adopted in 2019, 50 percent were white, 18 percent were black children and 20 percent were Hispanic children. The number of adoptions has increased significantly since ASFA when fewer than 30,000 children were adopted annually.

Adoption of children from foster care has been an important focus within child welfare and it was one of the major issues addressed in the 1980 creation of Title IV-E funding (PL 96-272) when adoption assistance funding was created as an alternative to foster care. That same year, because of the Adoption Opportunities Act, 1980 saw the unveiling of national model legislation on state adoption standards.

At times, the promotion of adoptions has been a charged issue regarding racial equity due to the over representation of black children waiting to be adopted and how families are recruited in the adoption process. Legislation has attempted to address and mitigate disproportionality in the child welfare system. In 1994, the Multi-Ethnic Placement Act, referred to as MEPA (PL 103-382), sought to reduce the number of minority children who enter and remain in foster care by prohibiting federally funded foster care and adoption agencies from delaying or denying placement decisions “solely” on the basis of race, color, or national origin of either adoptive or foster parents or the children. Another provision required diligently recruiting racially or ethnically diverse foster and adoptive parents reflective of the children needing foster care and adoptive homes.

It has had its critics who feel that not enough was or is being done to prevent these foster care placements and not enough was or is being done to recruit black families to adopt. However, as enacted in 1994, MEPA did allow agencies, at least in legislative language, to consider the child's cultural, ethnic, or racial background, and the capacity of the prospective parents to meet the child's needs, as one of the factors used to determine the child's best interest.

In 1996, Congress revised the 1994 law (PL104-188) by removing the word “solely” so that it now read “denying a placement on the basis of race, color, nationality.” This amended version is now called the interethnic placement act or “IEPA.” Further, the amended law specified a penalty for violations of this state plan requirement, equal to 2 percent of Federal Title IV-E funds for a first violation, 3 percent for a second violation, and 5 percent for three or more violations. Private agencies that violate the interethnic provisions are required to pay back any Federal funds received. Under the current law, private individuals may continue to seek relief in U.S. district court.

In 2003, HHS issued ACYF-CB-IM-03-01, signed by Assistant Secretary Children and Families Wade Horn, said in part: “This Information Memorandum reiterates and confirms my long standing and unequivocal support for the letter of, and spirit underlying, the Multiethnic Placement Act, as amended by the MEPA (Section 1808). This administration will not tolerate

discrimination in foster care and adoption placement decisions and will enforce Section 1808's provisions to the extent of the law.”²²

Within the adoption community critics of the law and the 2003 guidance felt it had a chilling effect on agencies that were recruiting, providing training, and providing culturally appropriate services for families seeking to adopt. They also saw that the law was not placing enough effort on diligent recruitment of more diverse families that had been a part of the 1994 law. A 2009 GAO report, well after MEPA, examined disproportionality and stated:

“Policies that promote adoption of African American children were generally viewed as helpful, such as allowing states to classify African American children as having “special needs,” which allows them to provide subsidies to adoptive parents, according to our survey results. However, views of other requirements were mixed. Although 22 states reported that the federal policies requiring states to diligently recruit ethnically and racially diverse adoptive families would help reduce disproportionality, 9 states reported the federal requirements had no effect, and 15 states reported that they were unable to tell.”

States continue to face challenges in recruiting adoptive families---such as a shortage of willing and qualified parents, especially for older African American children, or a lack of resources for recruiting initiatives. Any evaluation of racial equity within child welfare policy must include a re-evaluation of MEPA and IEPA.

Health care

One prime example of policies that are mainly outside of child welfare that impact disproportionality has been our national, state, and local laws and practices that address substance use and treatment for any drug epidemic. On occasion, there has been a failure by both policymakers and the advocacy community to approach this issue equitably.

Congress and state governments' most recent efforts to address the opioid epidemic have correctly focused on treatment needs and strategies to cut-off the supply of drugs without treating the individual with an addiction as a criminal. There has been sympathy toward families and those suffering an addiction that has not always been this nation's past approach. This is a major advancement from earlier history, especially in comparison to the crack-cocaine epidemic use in the 1980s and 90s.

When the spread of crack cocaine was taking place in the 1980s and 1990s this addiction was addressed in a more punitive way. Rather than investing significant new funds for drug treatment, a “get-tough-on-crime” approach was used. Some policymakers may not have intended to target communities of color but when they addressed crack-cocaine, it was not from a treatment perspective. A few years later when Congress began to address a regional methamphetamine epidemic within child welfare services, that too—like the reaction to opioids, was a less punitive approach. In reality, crack-cocaine addiction was being felt more in black urban centers while both the opioids and methamphetamines was having its greatest impact on rural and suburban white areas.

Congress's creation of the Regional Partnership Grants (RPGs) of 2006²³ included an original preference for grant awards that targeted methamphetamines addiction over alcohol addiction or other addictions. That meant a greater focus on rural and predominantly white populations where methamphetamines were spreading at the time. That preference was removed five years later. More recently the opioids epidemic has been felt more in rural white and suburban areas. The positive aspects of the focus on both methamphetamines and opioids are that the national policies have increased the need for greater treatment options. This more positive approach did not exist in the 1980s crack-cocaine epidemic which hit largely urban and black populations. Policymakers need to dedicate themselves to a treatment approach regardless of the communities most affected—colorblind to treatment needs and law enforcement actions.

Poverty

As we had highlighted in our 2009 transition paper, research indicates poverty as a contributing factor to disproportionality. A 2007 GAO report on African American children in foster care found that 23% of African Americans lived below poverty levels, compared with only 6% of whites.²⁴

More than a decade later, in 2019 the National Academy of Sciences in their report, *A Roadmap to Reducing Child Poverty (2019)*, pointed out the potential impact poverty can have on a child and child development. “Some children are resilient to a number of the adverse impacts of poverty, but many studies show significant associations between poverty and child maltreatment, adverse childhood experiences, increased material hardship, worse physical health, low birth weight, structural changes in brain development, mental health problems, decreased educational attainment, and increased risky behaviors, delinquency, and criminal behavior in adolescence and adulthood. As for the timing and severity of poverty, the literature documents that poverty in early childhood, prolonged poverty, and deep poverty are all associated with worse child and adult outcomes.”²⁵

During the past few months of discussion on the level of child abuse reporting, many people have confused or combined the issue of child “maltreatment” with poverty. They have pointed out, correctly, that a majority of substantiated child maltreatment cases are categorized as neglect. But they then conclude that substantiation of child abuse is based on poverty. It is much more complex.

Child neglect and what is sometimes referred to as chronic neglect (repeat instances) is highly correlated with poverty, although most people living in poverty do not neglect their children (Gaudin, 2009—footnote Humane). In analyzing the incidents of “chronic neglect” the Children’s Bureau’s Information Gateway issued a paper²⁶ that described the stressors on families that came to the attention of CPS due to chronic neglect:

“Several parental stressors are associated with chronic neglect, including poverty, mental health issues, and substance abuse (Tanner & Turney, 2003; Wilson & Horner, 2003). Of all forms of maltreatment, neglect has the strongest relationship to poverty (Loman, 2006). This relationship is not causal but contributory neglect is strongly associated with measures of socioeconomic disadvantage, which include welfare dependence, homelessness, low levels of education, and single-parent families—as well as limited income.”

The National Academy study further highlighted research comparing children whose families had incomes above twice the poverty line during their early childhood with children whose families had incomes below the poverty line during this early childhood period. Those children completed 2 fewer years of schooling; as adults worked 451 fewer hours per year; earned less than one-half as much; received more in food stamps and were more than twice as likely to report poor overall health or high levels of psychological distress (footnote). They went on to say:

“The weight of the causal evidence indicates that income poverty itself causes negative child outcomes, especially when it begins in early childhood and/or persists throughout a large share of a child’s life. Many programs that alleviate poverty either directly, by providing income transfers, or indirectly, by providing food, housing, or medical care, have been shown to improve child well-being.”

We have seen in 2020, due to COVID-19, just how disadvantaged minority populations are through the health data provided by the CDC. We also know that these families are more likely to be on the frontlines through service industry jobs, therefore, risking their health. They may be suffering disproportionately when it comes to pandemic-related housing issues and surviving economically when they lose their lower paying jobs due to the pandemic.

There needs to be action on the National Academy of Sciences and their policy recommendations in their report, *A Roadmap to Reducing Child Poverty*. We need to cut child poverty in half within ten years. We also need to pursue additional policy options that can strengthen families by reforming programs such as TANF, addressing the growing homelessness and affordable housing problems, and by building on the original improvements through the Affordable Care Act (ACA) to increase health care coverage and access to vital substance use and mental health services.

Workforce and Workforce Development in Child Welfare

A recent writing by the ABA’s Center on Children and the Law cites a January 2017 report from the state of Washington, “African American children were 2.2 times and Native American children were 2.9 times more likely to be placed in out-of-home care compared to white children.”²⁷ Other studies have focused on the limitation and access to preventive services and the overrepresentation of children of color in the child protection system.

One of the factors that may affect what services a family receives is the workforce. As we have highlighted for years, the workforce is critical to positive outcomes for families. It is the bedrock for any improvements and sustained reforms. A bedrock we do not support.

According to *Fostering Change for Children* based in New York City, “Up to 40% of child welfare caseworkers leave their jobs every year, while 90% of agencies report difficulty hiring and retaining qualified staff. This has devastating consequences for children and families. Children with one caseworker achieve permanency in 75% of cases. But the more caseworkers involved in a child’s life, the less chance that child has to achieve permanency, ranging from 17.5% for children with two caseworkers, to the devastatingly low rate of 0.1% for children who had six or seven caseworkers during their time in care.”²⁸

An issue that is frequently raised regarding the issue of disproportionality in the child welfare whether we are talking about primary prevention services or child protection or placement is the potential impact of “implicit bias” within a given workforce. A well-meaning and effective workforce training program will be limited if that workforce is in a constant state of turnover. A recent article in *Psychology Today* described implicit bias in this way:

“Consider the following example: Imagine you are an employer who interviews a candidate for a highly coveted position. Ideally, your decision to hire this person would be based only on the candidate’s qualifications. You might try to achieve this by creating the optimal conditions for considering only relevant information. For instance, you might set yourself the conscious goal to pay attention only to relevant information such as the content of the CV. You put aside all other distractions like your cellphone so that you can devote your full attention to the interview, and you take enough time out of your schedule for making the decision.

Research strongly suggests, however, that your decision might still be influenced by the race and gender of the applicant. Such an impact of race or gender would be an example of implicit bias. You are influenced in a systematic manner (i.e., you are biased) by elements in your environment (e.g., the skin color of the applicant) even though you did not intend to be influenced and were focusing on other things (i.e., it happened implicitly).”²⁹

Some agencies and workplaces have designed training programs and practices to address these cultural barriers. As noted, the Commission to Eliminate Child Abuse and Neglect Fatalities included several approaches. One way *not* to address the issue is through the September 2020, Presidential Executive Order, “*Combating Race and Sex Stereotyping*” which takes the exact opposite approach to address diversity training and practices.

Even with the proper tools, trainings, and cultural shifts, these actions may fail if we continue to not address the child welfare workforce.

Child welfare work is labor intensive. Workers must engage families through face-to-face contact, assess children’s safety and well-being through physical visits, monitor progress, see that families receive essential services and supports across multiple systems, help with problems that develop, and fulfill data collection and reporting requirements.

These are not new challenges as we cited a GAO report ten years ago that documented this crisis in the child welfare workforce, finding the child welfare system is seriously understaffed, undertrained, and undervalued. GAO found these workforce problems limit states’ ability to meet the goals established in the CFSRs.³⁰

Recruitment is an important first step in building a child welfare workforce. There are models such as the New York City-based Children’s Corp that works in cooperation with the City and higher education institutions to both recruit and support new workers for child welfare agencies. It and other models need to be encouraged and expanded nationwide and funded.

The federal government must also step up. In 2008, Congress reauthorized the Higher Education Act and as part of that reauthorization, Congress created a loan forgiveness program that covers

child welfare workers working for public or private agencies (as well as several other human service categories). This program could provide up to \$2,000 of loan forgiveness for each of the first five years a social worker remains at an agency. Congress never bothered to fund it despite it still being on the books.

In that same year, Congress created a ten-year loan forgiveness program for a range of public services workers providing an ultimate forgiveness of the remainder of a student loan if the student worked in various public services roles, including child welfare workers. That too has not lived up to its promise as the first collection of qualified workers, after ten years of loan payments, did not receive the forgiveness due to structural problems with the student loan programs.

A small amount of funding exists under Title IV-B part 1 Child Welfare Services that can help these kinds of initiatives. Now set at \$7 million, this funding should be increased enough to encourage greater efforts and university partnerships in all 50 states. In addition, states receive \$20 million a year for workforce development if they meet their annual caseworker visit requirements. Both of these funding totals are inadequate to truly fund substantial workforce development strategies.

The federal government needs to increase its support and funding for education and labor funded workforce development as well as provide anti-bias training to both train and support the workforce and then retain those same dedicated servants.

Recommendations

Short-Term

The new Administration should:

- Repeal the September 2020 presidential executive order, “Combating Race and Sex Stereotyping” which attempts to undercut efforts at diversity training and practices.
- Adopt the following administrative recommendations by the Commission to Eliminate Child Abuse and Neglect Fatalities, which proposed prioritized guidance and policies to promote agency self-assessment and worker training to address racial equity. These include:
 - Incorporation into the Child and Family Services Reviews an indicator of the degree to which racial disproportionality is found within various aspects of a state's child welfare system.
 - Encourage states to promote examples, such as the National Council of Juvenile and Family Court Judges (NCJFCJ) Bench Card, to expose practitioners to decision making tools that are focused on addressing bias directly
 - Require racial equity training across federal, state, and local child welfare agencies and other child-serving systems to ensure that families disproportionately represented are supported by a workforce that is trained around equitable decision-making.

- Bring together all the state Medicaid Directors, Child Welfare Directors, and State Substance Abuse Directors (at the very least child welfare and substance use directors) in a coordination and planning conference that can facilitate and expand substance use and prevention services through the three services funded under the three state departments/agencies
- Assist states in the use of such innovations as differential or alternate response or other variations within the Child Protective Services system that can help families access needed services to keep their children safe while maintaining child protection in addressing child abuse and child sexual abuse.
- In instances where disproportionality is pervasive, prioritize training of the child welfare workforce, partners, and mandated reporters on several important challenges.
- Revise current guidance on the Multi-Ethnic Placement Act to encourage appropriate training and recruitment strategies to increase and improve recruitment strategies that expand on the number of minority families interested in adoption.
- Expand research and development through various child welfare funding sources that create assessment and training tools that can address impact bias throughout the child welfare system from prevention through placement services.

Long-Term

Congress and the new Administration should:

- Amend the state option under the 2008 Foster Connections to Success and Increasing Adoptions Act to require all fifty states to extend Title IV-E subsidized kinship care guardianship assistance program.
- Amend the Title IV-E subsidized kinship care guardianship assistance program by eliminating the required six-month waiting period before a child (in foster care with the relative caregiver) can be permanently placed into a subsidized guardianship arrangement with that relative.
- De-link subsidized guardianships from the 1996 AFDC income standard
- Amend the Inter-Ethnic Placement Act to allow consideration of race and ethnicity in permanency planning and in preparing families who are adopting transracially. Sound, ethical adoption practice requires attention to racial and ethnic issues, so that the original MEPA standard—which (when in the individual best interest of the child) provided that race may be a factor, but not the sole factor, to be considered in selecting a foster or adoptive parent for a child in foster care—should be reinstated. Similar to the 1994 law’s intention, enforce and encourage greater diligent recruitment actions and policies.

- Provide substantial increases in the current \$40 million for the Adoption Opportunities Act to expand strategies on the diligent recruitment of minority families and families for older children and youth awaiting adoption in foster care.
- Create a new grant program through the Child Abuse Prevention and Treatment Act (CAPTA) to provide funding modeled on some state and local initiatives that encourage agencies to address implicit bias, and to create tools to promote diversity training.
- Increase the authorization for the state Child Abuse Prevention and Treatment Grants and Community-Based Child Abuse Prevention grants to no less than \$500 million each and follow through on full funding through the appropriations process in an effort to provide a substantial increase in primary prevention funding.
- Expand Earned Income Tax Credit (EITC) and the Child and Dependent Care Tax Credit (CDCTC) as recommended by the National Academy of Sciences report: A roadmap to Reducing Child Poverty

Equal Access to Services and Funding in Tribal Child Welfare

According to the 2010 Decennial Census, 0.9% of the U.S. population, or 2.9 million people, identified as American Indian or Alaska Native alone, while 1.7% of the U.S. population, or 5.2 million people, identified as American Indian or Alaska Native alone or in combination with another race. This is an increase since 2000 of over 39%.

There are 574 federally recognized Indian Nations (variously called tribes, nations, bands, pueblos, communities, and native villages) in the United States. About 29% of American Indians and Alaska Natives are under the age of 18, while 21.9% of the total U.S. population is under the age of 18. The median age on reservations is 29, while the median age for the total U.S. population is 38. According to the Census Bureau 2018 Population Estimates, the states with the highest proportion of American Indians and Alaska Natives are: Alaska (27.9%), Oklahoma (17.4%), New Mexico (14.5%), South Dakota (12%), and Montana (9.2%).⁵ By 2060, the projected U.S. American Indian and Alaska Native population is estimated to reach 10 million people, or approximately 2.4% of the U.S. population.³¹

Congressional hearings, beginning in 1974, led to the passage of the Indian Child Welfare Act (ICWA) in 1978. The hearings and the focus of the act were an attempt to address a significant problem reflected in studies between 1969 and 1974, which showed 25%–35% of all Native American children in some states were removed from their homes and placed in foster care or adoptive homes. In certain states, Native American children were 13 times more likely to be removed from their families than non-Indian children.³²

The intent behind ICWA was to preserve cultural and family ties among Native American children and families and to ensure respect for tribal authority in decisions concerning the placement of Indian children in out-of-home care and to prevent the past harmful actions and policies by the federal government and agencies acting in cooperation with the U.S. government.

Between 1958 and 1967, CWLA cooperated with the Bureau of Indian Affairs, under a federal contract, to facilitate an experiment in which 395 Indian children were removed from their tribes and cultures for adoption by non-Indian families.

Through this project, BIA and CWLA actively encouraged states to continue and to expand the practice of "rescuing" Native children from their own culture, from their very families. This example and many, many other historical policies, practices, and actions were why the Indian Child Welfare Act was necessary and why it was enacted. This was a vital step in attempting to adhere to tribal government to U.S. government agreements and respect.

ICWA requires states to identify Indian children and notify their parents and tribes of their rights to intervene in custody proceedings. ICWA also requires certain procedures regarding the use of tribal courts, child custody proceedings, tribal intervention standards, and placement preferences. The act establishes a two-part requirement for states before they remove an Indian child, which involves efforts to prevent the breakup of the Indian family, and standards for court findings.

At times there have been attempts to undercut its importance. In 2005, Congress directed GAO to study ICWA's impact and, in particular, determine if the law's requirements caused delays in the placement of Native American children. GAO concluded ICWA's requirements did not result in poorer outcomes for children. Few states in the GAO study kept detailed information, but those that did provided sufficient data demonstrating no clear link or evidence ICWA was having harmful effects. Interviews with tribes and states participating in the study indicated the law facilitated greater availability of resources and cooperation between tribes and states in protecting and providing services to Indian children.

A key finding from the GAO study was the problem of measuring and improving ICWA compliance when ICWA had no explicitly named oversight agency. Although ICWA established procedures and protections for placing Indian children in out-of-home care, adequate funding to provide these services did not follow. Comments submitted to GAO during its study indicated that, at times, the lack of resources for tribes hindered placements, and states relied on tribes for assistance in meeting ICWA's requirements.

Tribal child welfare services operate in a unique context shaped by laws, jurisdictional issues, cultural factors, financial constraints, and a federal trust relationship that is unlike any other in the states or territories. Efforts by more mainstream technical assistance centers—sometimes in partnership with tribal consultants or Indian organizations—to address tribal program capacity and professional worker development have been ongoing, but even more attention, and a truly dedicated technical assistance and training center, is necessary to properly address these unique issues. Establishing this type of center would more effectively organize resources to address tribal child welfare needs, and allow for fuller development of expertise, as well as new methods for delivering needed technical assistance and training.

In addition to barriers related to providing services, issues still remain in the disproportionate representation of children from tribal communities in the child welfare system. National data and case studies validate the need to assess and eliminate factors that contribute to disproportionality. This disproportionate representation can be related to the disparities in the services Indian

children and families receive. For example, national data like that provided in 2018 indicate that of the 678,000 substantiated cases of child abuse in 2018, American Indian or Alaska Native children have the highest rate of victimization at 15.2 per 1,000 children in the population of the same race or ethnicity or 14,833 involved American Indian or Alaskan Native children.³³

What these numbers might show, however, is a lack of accurate national data. Individual state data from the same report show that the victimization rate was 41 per 1000 children in Alaska, 28 per 1000 in North Dakota, 27 per 1000 in Montana, 22 per 1000 in South Dakota and 12 per 1000 in Oklahoma.

The 2008 Fostering Connections to Success Act allows tribes direct access to IV-E funding. Before this legislation, tribes could not access Title IV-E funds to administer their own foster care or adoption assistance programs but instead had to enter into agreements with their respective state governments to access IV-E funds—agreements that more than half of the federally recognized tribes did not have.

Fostering Connections created the option for tribes or tribal consortia to directly access and administer IV-E funds by submitting a plan, including evidence of sound financial management, a description of the service area, and assurance that the use of Title IV-E funds will be for coverage of foster care, special-needs adoptions, and kinship guardianship assistance payment to only those children eligible for Title IV-E funds. As part of this new law, Fostering Connections provides \$3 million annually through HHS to provide technical assistance to assist interested tribes to directly provide foster care, adoption assistance, and (at tribal option) kinship programs. A tribe or consortia can receive a maximum one-time grant of \$300,000. ACF has awarded planning grants to 39 tribes since FY 2009. Seventeen tribes have been approved to operate the title IV-E program as of 2019.³⁴

The Fostering Connections to Success Act grants tribes' access to a portion of the state's Chafee Foster Care Independence Program funds and requires certain guarantees by the tribe to provide independent-living services for tribal youth in the state.

Aside from this reform, tribes have received very few funds from federal child welfare funding sources. The Family First Prevention Services Act does allow Tribes access to this new services funding. Funding is contingent on programs meeting the evidence-based standards of well-supported, supported or promising. Many programs and research on these programs may not have been adapted to meet the needs of these tribal communities. This is a challenge that HHS will have to address. Aside from these new funds, tribal governments and communities receive limited set-asides from Title IV-B, Parts 1 and 2—Child Welfare Services and Promoting Safe and Stable Families, respectively. Under Part 1, more than half of the tribal grants are less than \$10,000 each; under Part 2, most of the tribal grants are under \$40,000 each. Under CAPTA, tribes compete for a very small portion of funding with other organizations that serve migrant populations. Tribes are not eligible to receive direct funding from other grant programs and are forced to compete with states. Another important part of human services funding is the Social Services Block Grant (SSBG) which is currently at \$1.7 billion but throughout its history dating back to 1981, has never had a set-aside for tribes.

Although progress has been made because of ICWA, out-of-home placement of Indian children is still much greater for Indian youth than it is for the general population and Indian children continue to be regularly placed in non-Indian homes. Compliance with the ICWA by states is erratic and state court decisions are inconsistent. There is a great need for the federal government to provide binding regulations to ensure that the ICWA is enforced and applied properly in all states so that our children and families are fully protected.

In addition to these challenges, there have been recent court challenges to the integrity of ICWA. Most recently in 2018, a ruling by the U.S. District Court for the Northern District Judge Reed O'Connor ruled that the Indian Child Welfare Act (ICWA) is unconstitutional in its entirety based on the Equal Protection Clause and the 14th Amendment. The judge wrote that ICWA's racial classification of children has not been shown to serve a "compelling governmental interest."

At the time CWLA issued a statement criticizing the ruling, stating that the ruling "jeopardizes this landmark child welfare and child protection law and opens the door to weakening current protections for tribal children. Further, it ignores the direct federal government-to-government relationship"

Judge O'Connor found that the ICWA illegally gives Native American families preferential treatment in adoption proceedings for Native American children based on race, in violation of the Fifth Amendment's equal protection guarantee. O'Connor ruled that the law violated the 10th Amendment's federalism guarantees, specifically the "anti-commandeering" principle established by the Supreme Court. In his ruling, he dealt with tribal laws as a matter of race rather than a government-to-government issue—the very basis of ICWA.

The Appeals court rejected that thinking stating, "...ICWA preempts conflicting state laws and does not violate the Tenth Amendment anticommandeering doctrine; and ICWA and the Final Rule do not violate the nondelegation doctrine. We also conclude that the Final Rule implementing the ICWA is valid because the ICWA is constitutional..."

In 2016, the Obama Administration issued an AFCARS 2016 Final Rule which contained approximately 60 data elements related to ICWA. In 2019, the final rule was revised and eliminated 90% of the Adoption and Foster Care Analysis Reporting System (AFCARS) data elements relating to Native children in state child welfare systems and applicable requirements of the Indian Child Welfare Act (ICWA).

States, tribes, federal agencies, and policymakers need better data for Native children and families to understand how to effectively address persistent and long-term poor outcomes for Native children and families. The revisions eliminated many of the data elements that are needed to understand the unique issues that Native children experience related to poor outcomes in state child welfare systems.

When local ICWA data is available, tribes use it to identify discrepancies in state ICWA caseloads or to identify practice issues that need improvement. The 2016 AFCARS data elements would provide a consistent set of data that tribes and states could use to address ICWA challenges and other child welfare issues. Many of the ICWA data elements proposed for

elimination in the 2019 NPRM have the potential to help ACF support effective implementation of the Family First Prevention Services Act requirements with Native children and families such as active efforts and timely notice of proceedings.

Recommendations

Short-Term

The new Administration should:

- Restore the ACFARS data collection elements eliminated in 2019.
- Assist Tribes in accessing the new Family First Prevention Services funds.

Long-Term

Congress and the new Administration should:

- Create a new set-aside within the Social Services Block Grant (SSBG) for tribal governments with appropriate SSBG increases to offset state losses.
- Increase funding and the tribal set-asides within the Child Abuse Prevention and Treatment (CAPTA) state grants and Title II Community-Based Child Abuse Prevention (CB-CAP) grants.
- Modify the definitions of evidence-based programs under Family First Prevention Services to recognize the need for cultural adaptations for tribal communities

Cultural Competence and Gender Equity

As the demographics of the United States continue to change, child welfare agencies will encounter even more diverse families and will have to find a way to meet their needs effectively. Incorporating a cultural competency framework within the child welfare system can help agencies in their work with diverse families and likely reduce disproportionality because it helps eliminate biases. Culturally competent practices place primary focus on a child's well-being and safety while understanding well-being and safety within a cultural context. Understanding cultural factors within cases of child abuse and neglect allows for appropriate prevention and interventions measures to effectively address the family's needs.

The Child Welfare League of America enters its second century in 2021. Throughout that history, our membership has included many private and faith-based agencies, as well as public agencies, all in service to these children and their families. We, and all of our member organizations, have changed with the times. There are practices and standards that existed in 1920 that would simply be inappropriate today, even if they were well-intentioned or based on what we knew then.

One factor that has been consistent for the past 100 years is the fact that those agencies always sought, and do seek, to place children first. Placing children first, and their “best interests” first, has meant changing from past practices.

Over time, we have benefited from scientific advancement that has led to a better understanding of brain development a better understanding of child and youth development; and an always evolving societal and political history that has resulted in cultural, racial, ethnic, and religious changes. These changes, in many instances, involved the rejection of prejudice and practice based on racial, ethnic, religious, and tribal differences. Rejection of these prejudices have made us stronger as a nation and has allowed us to place the primacy of children and youth first.

The “best interests” of children, as written into federal law under Title IV-B and Title IV-E of the Social Security Act, cannot be served if we turn this into a political fight that is more about which providers receive federal money while children wait for their best interests to be served.

CWLA history includes our efforts in support of LGBTQ children, youth, and families by working in partnership with Lambda Legal, the nation's oldest and largest civil rights organization dedicated to supporting LGBTQ people, as well as people with HIV or AIDS. In 2014 CWLA and Lambda Legal have created an initiative entitled Fostering Transitions: CWLA/Lambda Joint Initiative to Support LGBTQ youth and Adults Involved with the Child Welfare System. The goal was to increase the child welfare system's capacity to meet the needs of lesbian, gay, bisexual, transgender, and questioning (LGBTQ) children, youth, adults, and families.

As we have said on behalf of CWLA membership or in partnership with other national organizations, we believe that children deserve every opportunity to have a permanent, loving family, and that ruling out qualified prospective parents through discrimination limits options for permanency and stability for children waiting in temporary arrangements.

We oppose policies and practices that categorically discriminate against prospective parents, including but not limited to discrimination based on age, race, ethnicity, gender, sexual orientation, gender identity, religion, marital status, family size, disability, medical condition, geographic location, employment status, occupation (including employment in the child welfare system), and educational attainment.

We support making decisions about approving prospective parents and matching waiting children on a case-by-case basis, based on the strengths of the family, safety of the home and the best interests of each child. Based on more than three decades of social science research, we believe that families with LGBT members deserve the same rights and levels of support afforded other families. Any attempt to preclude or prevent LGBT individuals or couples from parenting based solely on their sexual orientation or gender identity is not in the best interest of children. Scientific evidence demonstrates that children who grow up with one or two parents who are gay or lesbian fare as well in emotional, cognitive, social, and sexual functioning as do children whose parents are heterosexual.³⁵

In November 2019, the Administration announced a significant change to federal non-discrimination policy in regard to the Department of Health and Human Services. This action comes on top of previous actions over the past three years that enhanced and encouraged states to enact policies and laws that discriminate in the recruitment of parents and guardians and the placement of children and youth.

As we said last year, the repeal of certain non-discrimination protections, rules, or laws as they apply to child welfare placements is not helping to create the kind of national discussion we need and is hindering the nation's ability to care for more than 687,000 children who will spend at least part of their year in foster care.

This action by the Administration came along with earlier actions that restricted data collection through the AFCARS revised rule. The earlier rule that would have provided important new data in terms of serving children and youth

According to the National Survey of Child and Adolescent Well-Being-II (NSCAW-II), approximately 22.8 percent of children in out-of-home care identified as LGBTQ+ (Martin, Down, & Erney, 2016). Research also shows that LGBTQ+ youth are overrepresented in foster care. According to a recent study in Los Angeles County, for example, approximately one out of every five foster youth identified as LGBTQ+ (Human Rights Campaign, 2015). Studies also show that youth in foster care who identify as LGBTQ+ have lower self-esteem and a much greater chance of health problems as adults (Child Welfare Information Gateway [CWLA], 2013). They are more than three times more likely to abuse illegal substances, three times more likely to be at high risk for contracting HIV and other STDs, almost six times more likely to experience high levels of depression, and more than eight times more likely to attempt suicide than their peers in foster care who do not identify as LGBTQ+ (CWLA, 2013).³⁶

A report published by the Department of Health and Human Services, as a result of 2014 legislation reauthorizing the Title IV-B programs, provides an analysis of factors associated with youth who run from foster care. Regarding sexual orientation the report stated:

“Lesbian, gay, bisexual, transgender, and questioning (LGBTQ) youth are more likely than heterosexual youth to run from home in the general population, and preliminary evidence suggests a similar pattern among the foster care population. A large, longitudinal study of youth in state custody assessed runaway behavior among youth with issues related to sexual development, defined broadly as “difficulties related to sexual development, including sexual behavior, sexual identity, sexual concerns, and the reactions of significant others to any of these factors” (Taylor, 2013). Such youth were 17 percent more likely than other youth to run from care and were also more likely to have an increased number of days on the run. These findings are consistent with findings that youth in the general population who identify as LGBTQ are overrepresented in the homeless population and are more likely than youth who identify as heterosexual to be runaways or throwaways (i.e., evicted from their homes by parents; Cochran, Stewart, Ginzler, & Cauce, 2002; Corliss, Goodenow, Nichols, & Austin, 2011; Whitbeck, Chen, Hoyt, Tyler, & Johnson, 2004). Sexual orientation and gender identity may be particularly critical factors to examine among runaway youth, because they often emerge in middle to late adolescence—a time of high running risk (Nesmith, 2006).³⁷

In the 2010 CWLA Press publication *LGBTQ Youth Issues: A Practical Guide for Youth Workers Serving Lesbian, Gay, Bisexual, Transgender, and Questioning Youth*, author Gerald P. Mallon states that:

“There must be a system-wide recognition of the fact that negative attitudes toward homosexuality and discrimination against LGBTQ youth contribute significantly to the difficulties that these youth encounter. Youth care professionals need to acknowledge the existence of young LGBTQ people and develop ways to educate themselves—as well as the families of children in care—in order to understand the significance of sexual orientation in young peoples’ lives.”

To restate what we have said many times before, based on a preponderance of existing research substantiating the ability of gay, lesbian, and bisexual adults to serve as competent, caring, supportive and loving parents, and consistent with the Standards of Excellence for Child Welfare Services, CWLA commits its experience, its resources, and its influence to supporting LGBTQ children, youth, adults, and families involved in America’s child welfare system. Congress and the Administration needs to enact legislation that will clarify that discrimination on the basis of gender, sex or sexual preference is not in the best interest of children, or society.

Recommendations

Short-Term

The new Administration should:

- Reinstate the protections that were repealed in November 2019 that prohibited discrimination within programs under the jurisdiction of the Department of Health and Human Services.
- Reinstate the data collection requirements included in the AFCARS final rule of 2016 in regard to LGBTQ data elements.
- Suspend waivers issued by the Administration that allow for discrimination in recruitment and placement within the child welfare system.

Long-Term

Congress and the new Administration should:

- Pass legislation, such as the Every Child Deserves a Family Act, that will prohibit discrimination in placement and recruitment decisions by amending Title IV-E and Title IV-B of the Social Security Act

CHAPTER 2: Preventing Child Abuse and Neglect

A new national strategy to prevent child abuse and neglect must be one that offers children hope of attaining familial love and emotional support. Such a strategy must involve all segments of society in offering help and hope to individual children, parents, and families.

Those words could be written today in 2020 but they are from a May 1994 report by the U.S. Advisory Board on Child Abuse and Neglect issued those words along with a report to Congress: “***Neighbors Helping Neighbors: A New National Strategy for the Protection of Children.***”³⁸

The Advisory Board went on to outline four components to the foundation for such a strategy each with equal importance: first, a national strategy must be comprehensive; second, a national strategy must be neighborhood based; third, a national strategy must be child centered; and fourth, a national strategy must be family focused.

We are once again starting to examine ways for more community-based solutions that, in the vernacular of the 2020s can “strengthen families” just as that Advisory Board called for support for family resource centers, joint efforts of foundations and governments to fund “prevention zones,” called for all child protection programs at all levels to increase the emphasis on preventing child abuse and neglect, providing treatment, and new standards for investigative responses that could enhance prevention strategies.

It is well to ask, how far have we come from that report issued more than 25 years ago.

Child Maltreatment Report

The U.S. Department of Health and Human Services (HHS) releases the latest national data on child abuse and neglect during the December to January time period. On January 15, 2020, the Children’s Bureau released the annual child abuse and neglect report: *Child Maltreatment 2018*. The numbers showed an increase in the rates of abuse and neglect for the first time since 2015, with infants and young children having the highest increase in child maltreatment. For the federal fiscal year 2018, there were an estimated 678,000 substantiated victims of child abuse and neglect. The victim rate is 9.2 victims per 1,000 children in the population.³⁹

Child Protective Services (CPS) agencies received a national estimate of 4.3 million referrals involving approximately 7.8 million children. Fifty-six percent of referrals were screened in, and 44 percent were screened out in the fiscal year 2018. Fifty-two states screened in 2.4 million referrals for a CPS response.

As far as who reports cases of abuse and neglect, professionals submitted 67.3 percent of reports. Professionals included teachers, police officers, lawyers, and social services staff. As in past years, education personnel (20.5%) accounted for the single biggest percentage of reporters followed by legal and law enforcement personnel (18.7%), and social services personnel (10.7%). These are all mandatory reporters under various state laws. Nonprofessionals—including friends, neighbors, and relatives—submitted more than one-sixth of reports (16.6%).

According to the annual report:

- Children in their first year of life have the highest rate of victimization at 26.7 per 1,000 children of the same age in the national population.
- American Indian or Alaska Native children have the highest rate of victimization at 15.2 per 1,000 children in the population of the same race or ethnicity, and African American children have the second-highest rate at 14.0 per 1,000 children of the same race or ethnicity.

In more recent years, the annual maltreatment report has greater information on substance use:

- The number of victims reported with a caregiver who had an alcohol abuse risk factor showed an increase from 11.6 percent in 2016 to 12.3 percent in 2018.
- The number of victims reported with a caretaker who had a drug abuse caregiver risk factor also increased from 28.9 in 2016 to 30.7 percent in 2018

For the fiscal year 2018, the greatest percentage of children suffered from neglect (60.8%), 10.7 percent of victims suffered from physical abuse, and 7.0 percent were sexually abused. These victims could be substantiated for a single maltreatment type or a combination of two or more maltreatment types.

For the fiscal year 2018, an estimated 1,770 children died of abuse and neglect at a rate of 2.39 per 100,000 children in the national population, an increase of 3.5 percent from last year's national estimate of 1,710 child fatalities. Seventy-one (70.6%) percent of all child fatalities were younger than three years old, with nearly one-half of child fatalities being children under the age of 1.

- Boys had a higher child fatality rate than girls at 2.87 boys per 100,000 boys in the population.
- Girls had a child fatality rate of 2.19 per 100,000 girls in the population.
- The rate for African American child fatalities was 5.48 per 100,000; the rate for white children was 1.94 per 100,000 children; and 1.63 per 100,000 Hispanic children.

An estimated 2 million children received prevention services in the fiscal year 2018. Post-response services are reported by the state as services that were initiated or continued due to an investigation response or alternative response from a child welfare agency.

- Two-thirds (60.7%) of victims and one-third (29.0%) of nonvictims received post-response services.
- Approximately 2.0 million children received prevention services.
- Nearly 1.3 million children received post-response services from a CPS agency.

While this data from 2018 is very similar to recent previous years, the COVID-19 pandemic and the racial equity debate has highlighted the fact that such a high percentage of substantiated cases are due to neglect. Added to this reality was the early evidence that when the school systems across the country shut down in the spring of 2020, there was a reduction in the number of child abuse reports, presumably because educators represented 20 percent of the source of reports.

Child Protection Systems (CPS)

Child protection can trace its origins to the 19th Century when, in 1875, the Society for the Prevention of Cruelty to Children was established in New York City. After publicity surrounding the treatment of a young child captured the public's attention, the President of the American Society for the Prevention of Cruelty to Animals was approached and, as a result of his support, existing state legislation was used to protect children for the first time. Other states and jurisdictions would eventually follow by enacting their own laws. In 1899, Illinois became the first state to create a juvenile court to address issues of dependence, delinquency, and neglect. By 1907, 26 states had followed with their own juvenile court laws.⁷

The first White House Conference on Children was convened in 1909; one of the results of that conference was the creation of a Children's Bureau at the federal level. Part of the mission of the new bureau, at the urging of the White House Conference, was to "investigate and report on all matters relating to the welfare of children and child life among all classes of people."⁸

Throughout the following decades, other federal and state laws were enacted, but in 1962, Dr. C. Henry Kempe's work on "battered child syndrome" raised the importance of communities in their efforts to protect children and led the medical community to improve methods of identifying and protecting children from abuse. In 1974, Congress passed the first Child Abuse Prevention and Treatment Act (CAPTA). This landmark law helped establish national standards for specific reporting and response practices for states to include into their child protection laws.

COVID-19-Racial Equity

The COVID-19 pandemic has focused greater attention on racial inequality across this country and across systems and services. Early data released in June 2020 by the Centers for Disease Control and Prevention (CDC) demonstrated real problems. CDC released data that examined the hospitalizations due to having COVID-19 and it showed that when the data was broken out by racial and ethnic impact as well as the impact on patients with underlying health risks there was a disproportionate impact. Among 599,636 (45%) hospitalization cases with known information, 33% of persons were Hispanic or Latino of any race (Hispanic), 22% were non-Hispanic black (black), and 1.3% were non-Hispanic American Indian or Alaska Native (AI/AN). These same inequities show up in COVID-19 related and recession-related impacts of on the economy, access to health care, public health services, employment issues, schooling access, and how essential workers are affected.⁴⁰

In turn, the pandemic has raised questions or started discussions on why there is, or always has been, a disproportionality regarding the child abuse reports and reporting.

With schools out of session or restricted to a virtual format, state and local reports showed that calls to hotlines and other child abuse reporting mechanisms were down significantly, which raised concerns for many observers. The belief has been that families were more isolated, under greater economic threat in housing, nutrition and other human services. According to sources such as Futures Without Violence, the pandemic has increased the instances of intimate partner violence and other abuse.⁴¹

At the same time local reports showed a decrease of calls. In New York City, during the first eight weeks of spring 2019, the city received an average of 1,374 cases of abuse or neglect to

investigate each week but a year later the number fell to 672, a decline of 51 percent.⁴² Later reports in 2020 suggested a different result in some jurisdictions with Chicago authorities indicating that earlier in the year reports had declined by a similar percentage but the state revised its reporting system through a web-based design. As a result, reports were still down by 18 percent in September 2020, but reports submitted online more than doubled and officials said that despite pandemic declines in reporting, their number of investigations have actually increased compared to last year.⁴³

As a result of these realities new or renewed discussions have been raised as to how we should reach out and support families while protecting children who are vulnerable to abuse.

This is not the first time this issue has been raised. As noted in the U.S. Advisory Board on Child Abuse and Neglect: “***Neighbors Helping Neighbors: A New National Strategy for the Protection of Children,***” did include recommendations to avoid undue emphasis on investigation while increasing prevention.

At the time of the 2010 reauthorization of CAPTA, the Senate HELP Committee report on the CAPTA reauthorization outlined the core elements of an “alternate track” or “differential response” system which attempts to serve families in a different way:

“Differential response is a State or community-determined formal response that assesses the needs of the child or family without requiring a determination of risk or occurrence of maltreatment. Such response occurs in addition to the traditional investigatory response.”

Based on research through a federally funded Quality Improvement Center (QIC) a differential response system as including eight distinct elements:

- (1) the use of two or more discrete responses to reports of maltreatment that are screened in and accepted by the child protection agency for response;*
- (2) pathway assignment determined by a variety of factors that may include presence of imminent danger, level of risk, the number of previous reports, among others;*
- (3) pathway assignment is flexible and can be changed with additional information;*
- (4) ability of families who receive a non-investigatory response to accept or refuse to participate in differential response;*
- (5) voluntary services for families who receive a non-investigatory response, as long as safety of child is not compromised;*
- (6) establishment of discrete responses is codified in State statute, protocols, and policies;*
- (7) no formal determination, such as substantiation or finding of abuse or neglect, that child maltreatment has occurred is necessary for differential response; and*
- (8) a differential use of the central registry, depending on the type of response so that there is no identification of individuals served through a non-investigation family assessment.*

There is debate over the various approaches states have used in implementing a ‘differential response’ with some states using a diversion system of referral that does not necessarily include support and help in accessing needed services but merely diverts to another agency such as

TANF. Other states have created a service and social work model that works with families to help them access and address issues that led to reports.

The most important point is that some have raised up the need to have a system that does allow an alternate approach to helping families that are not instances of abuse whereby the child is not in an unsafe circumstance. We need to review what we have learned, act on positive results, and commit additional support and research for genuine efforts to provide a safe alternative in appropriate cases.

Primary Prevention

Primary prevention can be those programs and services can be as basic as child care services which can help a parent handling the stresses of finding appropriate child care while working. Prevention includes the funding of family resource centers under the Community-Based Child Abuse Prevention used for family support programs, in collaboration with existing community-based health, mental health, education, employment and training services or it may include universal home visiting services.

We need to focus attention on those programs that have as their mission, at least in part, the prevention of child abuse as well as strengthening families. The federal government provides some limited funding intended to provide services that can prevent or remedy potential neglect and abuse situations as part of its mission.

It has been more than ten years since the Maternal, Infant and Early Childhood Home Visiting Program or *MIECHV* was created under the Obama Administration. It supports voluntary, evidence-based home visiting services during pregnancy and to parents with young children up to kindergarten entry. The initial program began with about a half dozen approved models but now there are at least 17 models.

The Health Resources and Services Administration (HRSA) tells us that 98 percent of states, territories and non-profits grantees showed improvement in at least four of six benchmarks including improving maternal and newborn health; prevention of child injuries, maltreatment, and emergency department visits; improving school readiness; reducing crime or domestic violence; improving family economic self-sufficiency; and improving service coordination and referrals for other community resources and support.⁴⁴

In 2019, 154,000 parents in 896 counties were served. That represented a tremendous increase of 350 percent since some of the initial funding in 2012.⁴⁵

According to HRSA, 70 percent of participating families had household incomes at or below 100 percent of poverty and 41 percent were at or below 50 percent of the federal poverty level. Twenty percent of households reported a history of child abuse and child maltreatment.

Over its first five years it was phased in with increasing funds and had reached \$400 million by year five. That is the same funding level provided today. According to the Administration, MIECHV serves 42 percent of the highest risk counties in the country as defined by low birth weight, teen birth rates, percent in poverty and infant mortality.⁴⁶ We are not doing enough. The

Family First Prevention Services Act (Family First Act) will allow some expansion of these home visiting models but that expansion will be contingent on the child welfare agency defining a child as a “candidate for foster care.”

We need to expand funding to MIECHV so that we cover 100 percent of the counties at high risk. We also need to assure that the Family First Act become an important source of expansion and support of home visiting so that this important start of life program becomes truly universal. We need to assure that whether through MIECHV funding or the new Family First Act funding, services must be provided to all parts of the state or geographic area. This is an example of how we can help reduce the overrepresentation of families of color in the child protection and child welfare system. When services are lacking to the families and communities that need services the most, we increase the possibility of pushing families into crisis.

Title IV-B Programs (Stephanie Tubbs Jones Child Welfare Services and the Marylee Allen Promoting Safe and Stable Families)

Title IV-B part 1, Child Welfare Services (CWS), and Title IV-B part 2, Promoting Safe and Stable Families (PSSF), are flexible funding streams that can fund a range of services, some to support families in an effort to prevent abuse.

These funding sources can sometimes fund innovative programs and services that wrap around vulnerable families. While PSSF is targeted to four categories of child welfare services of family preservation, family support, adoption support and reunification, CWS is broader and it has a long history of funding both CPS and prevention services.

What these two flexible funds lack *is* funding. PSSF topped off at \$405 million for the four services in 2003. CWS peaked at \$295 million in 1994 and is now down to \$269 million. If one of the greatest tools for primary prevention is state flexible funds for the child welfare agencies, then Congress needs to significantly increase funding for these two Title IV-B programs.

Increasing CWS funding significantly is a clear alternative to converting entitlement funding (foster care) into a waiver or block grant.

The Social Services Block Grant (SSBG) is an additional source of flexible state funding that can and does provide community-based initiatives. SSBG has had a long history of providing both CPS funding and prevention funds and has been a bigger source of funding than CAPTA and CWS. SSBG provided more than \$330 million in prevention, child protection and counseling services in the last annual report (2017 annual report).⁴⁷ SSBG should be protected and at least increased to allow for a first-time set-aside for tribal governments and consortia.

Child Abuse Prevention Treatment Act (CAPTA)

CAPTA is the only federal legislation exclusively dedicated to preventing, assessing, identifying, and treating child abuse and neglect—the continuum of child maltreatment services and supports. Since 1974, CAPTA has been part of the federal government’s effort to help states and communities improve their practices in preventing and treating child abuse and neglect. CAPTA

provides grants to states to support infrastructure and innovations in state child protective services (CPS).

CAPTA includes three programs:

- CAPTA authorizes grants to the states to develop innovative approaches to improve their CPS systems. To qualify for these grants, states must meet eligibility requirements, such as having mandatory reporting laws (although all fifty states had these in place by 1967), preserving victim confidentiality, appointing guardians ad litem, establishing citizen review panels, and various elements of child protection systems.
- CAPTA discretionary funds support state efforts to improve their practices in preventing and treating child abuse and neglect. These funds support program development, research, training, technical assistance, and the collection and dissemination of data to advance the prevention and treatment of child abuse and neglect. These funds also support the National Child Abuse and Neglect Data System (NCANDS), the only federal data collection effort to determine the scope of child abuse and neglect. These funds support national initiatives, such as the National Office of Child Abuse and Neglect, the National Resource Center on Child Maltreatment, and the National Clearinghouse on Child Abuse and Neglect.
- The Community-Based Family Resource and Support Program was created in 1996 by combining two other programs. The program provides grants to states to support their efforts to develop, operate, and expand a network of community-based, prevention-focused family resource and support programs that coordinate resources among a range of existing public and private organizations. Funding is allocated to states by a formula based on the number of children in a state's population.

The Child Abuse Prevention and Treatment Act funding can be used to improve practice and strengthen primary prevention. CAPTA has the word “prevention” embedded in its title since its creation in 1974. The challenge is that funding has been at less than \$27 million for most of this century. That means that more than a dozen states received less than \$200,000 a year in state grants. That is hardly enough to have a genuine impact. Congress needs to build on the small progress in appropriations since 2018 and provide enough funding so that we can make improvements in how we interact with families while protecting children in those instances when a child's safety and wellbeing is threatened.

The United States Senate HELP Committee report written in 2010 on the reauthorization of CAPTA provided a critical history of parts of CAPTA and prevention initiatives that we need to build on, 10 years later:⁴⁸

“In 1990, the Family Resource and Support Centers Program was established (by Public Law 101–501) to fund States, on a competitive basis, to establish statewide networks of family support programs, in collaboration with existing health, mental health, education, employment and training, child welfare, and other social services agencies within the State. HHS awarded three grants of \$1.5 million each to Maryland, Virginia, and Connecticut.

Each State took a unique approach to the operation of this program. One administered it through the State Health Department, another through the State Education Department, and the third through a private nonprofit entity.

Programs established under this authority were designed to operate consistent with the family support philosophy: the basic relationship between programs and the family is one of equality and respect; participants are a vital resource; programs are community-based and culturally and socially relevant to the families they serve; parent education, information about human development, and skill building for parents are essential elements of every program; and programs are voluntary.

The collaborative efforts of these programs resulted in critical innovations at the State level. These efforts also strengthened existing comprehensive programs in communities and tested innovative approaches at the local level. Services provided included parent education, early childhood development, outreach, community and social services referrals, housing assistance, job training, and parenting support, all of which help prevent child abuse.

The 1996 amendments to CAPTA rewrote Title II of the act and renamed it the Community-Based Family Resource and Support Grants...

The history of what is now referred to as CB-CAP has been one of stagnant and tiny funding. Between 2004 and 2019 the program was funded at approximately \$39 million a year in a federal budget that exceeded \$4.1 trillion before the pandemic. Funding was finally increased to \$55 million in 2020. Recent House COVID-19 relief measures go even further recognizing that in the crisis atmosphere that the pandemic and the recession have created for families means that we have to provide much greater support for these community-based family supports.

Congress needs to increase the authorized funding for both CAPTA state grants and CB-CAP grants to no less than \$500 million for each.

The Family First Prevention Services Act

The new Family First Prevention Services Act (PL115-123) offers the potential to supplement primary prevention services, although it is targeted toward the mission of preventing foster care placements. While eligibility is contingent on a child being a “candidate for foster care” it could still supplement some primary prevention efforts. To the extent it can supplement state home visiting programs, we can expand the availability of this important universal program. There may be some other opportunities to expand services within communities. A state’s implementation of a “plan of safe care” under the CAPTA mandate intended for instances when an infant has been exposed to substance use at birth is another potential primary prevention service that could potentially benefit. Much of this will be dependent on program approval through the HHS clearinghouse and research that could expand these approved services.

The Role of Other Family Services and Supports

All of the debate over the issue of child neglect has raised important questions regarding child protection as it relates to poverty and racial equity.

In 2019 the National Academy of Sciences in their report, *A Roadmap to Reducing Child Poverty (2019)*, pointed out the potential impact poverty can have on the child and child development. “Some children are resilient to a number of the adverse impacts of poverty, but many studies show significant associations between poverty and child maltreatment, adverse childhood experiences, increased material hardship, worse physical health, low birth weight, structural changes in brain development, mental health problems, decreased educational attainment, and increased risky behaviors, delinquency, and criminal behavior in adolescence and adulthood. As for the timing and severity of poverty, the literature documents that poverty in early childhood, prolonged poverty, and deep poverty are all associated with worse child and adult outcomes.”⁴⁹

During the past few months of discussion on the level of child abuse reporting, many people have confused or combined the issue of child “maltreatment” with poverty. They have pointed out, correctly, that a majority of substantiated child maltreatment cases are categorized as neglect. But they then conclude that substantiation of child abuse is based on poverty. It is much more complex.

Child neglect and what is sometimes referred to as chronic neglect (repeat instances) is highly correlated with poverty, although most people living in poverty do not neglect their children. In analyzing the incidents of “chronic neglect” the Children’s Bureau’s Information Gateway issued a paper⁵⁰ that described the stressors on families that came to the attention of CPS due to chronic neglect:

“Several parental stressors are associated with chronic neglect, including poverty, mental health issues, and substance abuse (Tanner & Turney, 2003; Wilson & Horner, 2003). Of all forms of maltreatment, neglect has the strongest relationship to poverty (Loman, 2006). This relationship is not causal but contributory neglect is strongly associated with measures of socioeconomic disadvantage, which include welfare dependence, homelessness, low levels of education, and single-parent families—as well as limited income.”

Child neglect can include what is sometimes referred to as chronic neglect (repeat instances) which is highly correlated with poverty, although most people living in poverty do not neglect their children (Gaudin, 2009)⁵¹. In analyzing the incidents of “chronic neglect” the Children’s Bureau’s Information Gateway issued a paper⁵² that described the stressors on families that came to the attention of CPS due to chronic neglect:

“Several parental stressors are associated with chronic neglect, including poverty, mental health issues, and substance abuse (Tanner & Turney, 2003; Wilson & Horner, 2003). Of all forms of maltreatment, neglect has the strongest relationship to poverty (Loman, 2006). This relationship is *not causal but contributory*—neglect is strongly associated with measures of socioeconomic disadvantage, which include welfare dependence, homelessness, low levels of education, and single-parent families—as well as limited income.”

In light of this reality, prevention does encompass some services as basic as access to child care, access to housing, home visiting, and especially income support through programs such as TANF and the child tax credits and the Earned Income Tax Credit (EITC).

Child Care and Early Childhood Education

The significance of child care is also being highlighted during this pandemic. Essential workers are dependent upon it. If those same essential workers are earning low wages, then child care becomes a bigger hurdle. Child care is more than just a work support for families, it is a critical strategy for assisting low-income families and providing quality early childhood education in the early years of child development.

This transition document will not deal in detail with child care except to state that both child care and *Head Start* funding and services have been inadequately addressed for most of this century. If we are to truly strengthen families then it has to start with quality early childhood education from child care to pre-kindergarten for all families. Congress needs to make sure that child care and the child care infrastructure survives this pandemic. We join national child care advocates the provision of an estimated \$50 billion to keep the industry intact through the pandemic and recession. Then Congress and the administration needs to guarantee child care and early childhood education to all families.

Inadequate Housing

In 1987, CWLA's President & CEO David Liederman testified at a House of Representatives hearing on legislation to amend the Fair Housing Act. He discussed how families were affected by a family's inability to find affordable, safe housing due to discrimination and availability. Two years later before the House Subcommittee on Housing and Community Development, he told Congress that "housing is probably the most critical issue in the country facing children today." He went on to say that children are unnecessarily removed because of the lack of affordable housing and that we needed to create subsidy programs that allow people to have access to affordable housing like we did in the 1950's, 1960's, and the early part of the 1970's.

Housing and fair housing continue to be a critical element in child welfare, prevention and strengthening families. In 1990, Congress partially responded to this with the creation of the Family Unification Program (FUP) as part of the Affordable Housing Act of 1990. A year later House Subcommittee Appropriations Chair Robert Traxler (D-MI) was successful in inserting \$35 million to fully fund the new FUP. It was the result of a joint advocacy effort of CWLA and National Organization of State Associations for Children (NOSAC).

Thirty years later we are still facing a housing crisis both before and especially now after the pandemic and recession. While support programs including FUP are important tools, the nation needs a much more comprehensive housing strategy as part of a child neglect prevention strategy.

Temporary Assistance for Needy Families (TANF)

We will withhold comment on the reauthorization of (TANF) for other parts of this document but income support programs that can lift families out of poverty and "deep" poverty are critical to any family strengthening prevention strategy. TANF can be a part of a state's job training strategy but it must also strengthen and support families. Its core mission remains "*provide assistance to needy families so that children can be cared for in their own homes or the homes of relatives.*"⁵³ Congress needs to revisit and actually reauthorize TANF at a higher level of funding with at least part of its mission supporting families and reducing poverty.

Family and Medical Leave

In addressing and creating family strengthening strategies that are not specific to the child protection and prevention system, Congress and the Administration needs to enact a family and medical leave law that is more expansive and extensive from the 1993 law and offers broader coverage than the 2019 law that expands coverage to federal employees.⁵⁴ Under the new law, eligible federal workers are entitled to 12 weeks of paid parental leave for the birth, adoption, or fostering of a child that occurs on or after October 1, 2020

It was at the 1989 CWLA National Conference, when Senator Christopher Dodd (D-CT) addressed CWLA members in support of his new Family and Medical Leave Act. That Family and Medical Leave Act would become law in 1993 (PL 103-3) and it represented a good first step but that was 27 years ago and it is now time to support all families.

According to MomsRising⁵⁵, paid family and medical leave combats poverty, gives children a healthy start, and lowers the wage gap between women and men by providing structural support to balance work and family.

Only 17 percent of Americans have access to paid family leave through their employer and fewer than 40 percent have personal medical leave provided through an employer. The current Family Medical Leave Act (FMLA) allows some employees to take up to 12 weeks of job-protected leave, but it only covers about 60 percent of employees. A quarter of all poverty spells in the United States are because of having a baby. The U.S is one of the only countries in the world that doesn't offer paid leave to new mothers. Paid family leave has been shown to reduce infant mortality by as much as 20 percent (and the U.S. ranks a low 37th of all countries in infant mortality).⁵⁶

The advocacy organization 1000 Days, issued a report in October 2020 that highlighted just how important family leave is:

“Paid family and medical leave is a powerful tool to protect public health, as well as the health and well-being of individuals and families. Paid leave supports healthier pregnancies, better birth outcomes and more successful breastfeeding, in addition to the physical and mental health of both mom and baby in the postpartum period. Universal access to a comprehensive paid leave program is also an important step in addressing maternal and infant racial and ethnic health disparities, helping to ensure that all moms and babies can have a healthy first 1,000 days.”⁵⁷

It is time to support parents in raising their families. In turn it strengthens our society and our future.

Recommendations

Short-Term

The new Administration should:

- Review and encourage efforts to implement alternate response or differential response approaches to child protection services. Review past research and further explore

successes and failures and how states might find new approaches to families that come to the attention of child protection systems.

- Speed up the approval process through the Title IV-E Prevention Services Clearinghouse or seek more funding through Congress to add funding to expand the reviews.
- Expand research into racial equity initiatives that can help address disproportionality within child protection.
- Expand research and funding into community-based initiatives that seek to strengthen community-based prevention services.

Long-Term

Congress and the new Administration should:

- Increase the authorization and appropriations for CAPTA state grants to \$500 million a year.
- Increase the authorization and appropriations for the CB-CAP, Title II CAPTA, to \$500 million a year.
- Reauthorize the Maternal, Infant and Early Childhood Home Visiting Program (MIECHV) and increase annual funding so that all “high-risk” counties are covered.
- Provide a full reauthorization of TANF, increase funding to address the loss in funding due to inflation (since 1996) and make the reduction of poverty one of the core purposes of the act.
- Increase funding for Title IV-B Child Welfare services to no less than the full reauthorization of \$325 million.
- Adopt a comprehensive universal paid family leave act for all families.
- Support the national child care system by providing emergency COVID-19 relief funding and then expand child care funding so that child care and early childhood education services are universal.
- Adopt the recommendations of the National Academy of Sciences in their report, *A Roadmap to Reducing Child Poverty (2019)*.

CHAPTER 3: Strengthening Families and Children Through Secondary Prevention and Intervention Services

Family First Prevention Services

The Family First Prevention Services Act of 2018 (P.L. 115-123) offers the potential to open a critical source of federal entitlement funding (Title IV-E of the Social Security Act) to services that can help families in crisis or families that are particularly vulnerable to separation. The

services that could be offered to these families include in-home services, mental health services, and substance use treatment and prevention services.

Due to the potentially open-ended nature of the funding, states are limited by two requirements in drawing down federal funds. First, spending on programs and services are limited to those approved programs that have been listed by a new clearinghouse in the Department of Health and Human Services. All programs must meet a standard of well-supported, supported, or promising based on past research and evidence. Secondly, the eligibility for services for the child and/or family is limited to those cases in which a child is considered a “candidate for foster care.” This means the family is at risk of a child removal and placement into foster care. States have flexibility in how broadly they define candidate and which families may be covered. For example, an infant born exposed to substances, or a child who has been reunified with their family could be considered candidates even though removal is not imminent. Eligibility is not tied to income and services can be for increments of up to 12 months, but the increments can be extended.

States will be eligible for a 50 percent federal match (the federal government picks up half the costs) and by federal fiscal year 2027, states will receive the same match they receive under Medicaid. The services funding is a state option and states have to submit a prevention plan that outlines what populations they will serve, what services they will provide and other requirements such as data on outcomes for the candidate and research on some of the programs being utilized.

Importantly, Tribes with an approved Title IV-E plan have the option to use these new prevention services and programs. HHS will specify the requirements applicable to tribes and further work to develop or allow cultural adaptation that best fits the tribal community. Since many of the approved programs or potential programs do not necessarily base their services on tribal community needs, this is a significant area of needed development.

Family First Prevention Services is not primary prevention but could more accurately be described as intervention services to prevent foster care. As the programs covered and used by states expand, it could be an important supplement to a state’s prevention strategy. For example, several of the home visiting programs have been approved for funding. A state could supplement a primary prevention strategy that involves universal home visiting services with a combination of funding sources including Family First Prevention Services.

As Family First plans are developed and implemented, there is also a potential that states could use this new funding source to more globally expand access to mental health and substance use services that would blend health care dollars, federal block grants and state funding.

The pandemic has created some new challenges for the Family First Act. As a recent paper by Children Trends points out: “Implementation of the Family First Act, including aspects of its evidence-based provisions, has similarly been impacted by the pandemic and resulting recession. In addition to the significant scope of changes to services, programs, and budgets required during the pandemic, state and local budgets are in crisis, resulting in limited capacity and reduced resources for agency leaders and staff to focus on a new initiative. From a practical perspective, implementing a major initiative requires a great deal of time, energy, and funding from

multiple stakeholders. Implementing new prevention programs will likely cause a huge strain on child welfare systems already in crisis due to the pandemic.”⁵⁸

In addition to the new budget constraints and multiple crises created by the pandemic, implementing the research that requires rigorous evaluation and data collection will be a new challenge not anticipated in the original law. To address this state will need flexibility in implementation and added funding to carry the much needed research and adaptation of research.

Title IV-B Part 1 and Part 2 Flexible Child Welfare Funds

Title IV-B of the Social Security Act includes two separate child welfare block grants that have both been renamed in the last several years: The Stephanie Tubbs-Jones Child Welfare Services (CWS) program and the Marylee Allen Promoting Safe and Stable Families program (PSSF). Both block grants are flexible funding streams that can fund a range of services, some to support families in an effort to prevent child maltreatment and abuse, as well as address family preservation and family support.

Child Welfare Services (CWS) is the oldest federal support for “child welfare” services through the Social Security Act. It precedes the creation of Title IV-E foster care and adoption assistance. It was expanded in 1980 when Title IV-E was created as the funding source that could help prevent removals.

As part of the IV-E creation, Congress set up a formula that allowed states that stayed below certain annual foster care spending target level to take the excess funds to be transferred to CWS. The goal was that the added flexibility would allow states to move funds from foster care to prevention services. One of the triggers for moving these funds from foster care was that CWS needed to be funded at its authorized level but throughout the 1980s that never happened. Today CWS is authorized at \$320 million but it has never received more than the \$295 million provided in 1994 and in fact is now (pre-pandemic) at \$269 million.

A few states have a grandfather clause that allow them to use some CWS funds for adoption assistance and foster care maintenance, but most states cannot use it in this way. What CWS is used for are a range of needs and services including child protection services (it provides more CPS dollars than the Child Abuse Prevention and Treatment Act). It is used by some states for primary prevention services as well as a range of services that are also funded under the PSSF including family reunification and family preservation.

Promoting Safe and Stable Families (PSSF) is more targeted to four family settings: Family Support, Family Preservation, Adoption Support, and Family Preservation—its original mission. This funding was created in 1993 as the first designated family preservation funding. It started out with the intent to fund these services as well as the broader “family support” services which are more prevention focused. This new family preservation funding was based on efforts such as the Homebuilders family preservation program. It adheres to strict standards, including very limited caseloads, caseworkers being available to families 24/7 for a limited number of weeks, and specified education and background for caseworkers. Homebuilders has been listed as an approved model under the Title IV-E Prevention clearinghouse.

As part of the 1997 Adoption and Safe Families Act (ASFA), this program was re-named and expanded in funding and services to include Adoption Support and Reunification. Since that 1997 expansion PSSF has had several adjustments and add-ons. A portion of PSSF funding (approximately) \$30 million is allocated for court improvement programs (CIP). These CIPs receive \$20 million in mandatory funding and in addition they receive \$9 million from the base PSSF program with 3.3 percent set-aside of any discretionary/appropriated funds now set at \$59 million.

The CIP has been an important source of training and coordination funds between state and local courts and state child welfare agencies. Its biggest challenge is that every time Congress reauthorizes the funding (usually every five years) just maintaining the funding at the same level requires Congress to find “savings” (cuts to other programs) just to keep the CIP at the same levels of spending.

Finally, in 2006, PSSF was expanded with two new funds. Twenty million is designated for competitive grants to address substance abuse (Regional Partnership Grants) while another \$20 million is set aside for workforce development. These workforce grants are allocated to states if they meet a requirement to visit children in foster care at least once a month.

The Need to Address Family Violence and Housing Needs

In a 1999 CWLA publication⁵⁹, *Building Bridges Between Domestic Violence Organizations and Child Protective Services*, we wrote: “Domestic violence advocates have learned that the concerns of battered women are inextricably linked to the welfare of their children and that the safety decisions of battered women are typically guided by the needs of their children.

...Over the last ten years, domestic violence advocates have learned that it will take a coordinated effort to effectively protect women and their children. No single organization can do this work by itself. Without collaboration and coordination among agencies, it is the battered women and their children who pay the price: their safety is jeopardized and their needs for security and stability are compromised.”

The safety of the child and the adult are linked and by helping adult victim of domestic violence the well-being of the children is enhanced but this is not always recognized in practice. In cases of domestic violence identifying and assessing domestic violence at all stages of the child protection process is critical to reducing the risks to the child. If the family’s circumstances are clear and it is appropriate, every effort should be made to keep the children in the care of the nonoffending parent.

Just as we have highlighted in other parts of this document, once again, poverty becomes an overarching factor in addressing these family violence circumstances. An adult victim may have limited ability to be financially self-sufficient. A lack of job skills, education, and income presents huge challenges for victims because the adult caregiver may want to leave their violent relationship, but they have few economic choices. Added to these questions of poverty homelessness and unsafe housing are common realities for low-income victims and their children who want to escape domestic violence.

In 1987, CWLA's President & CEO David Liederman testified at a House of Representatives hearing on legislation to amend the Fair Housing Act. He discussed how families were affected by a family's inability to find affordable, safe housing due to discrimination and availability. Two years later before the House Subcommittee on Housing and Community Development, he told Congress that "housing is probably the most critical issue in the country facing children today." He went on to say that children are unnecessarily removed because of the lack of affordable housing and that we needed to create subsidy programs that allow people to have access to affordable housing..."

In 1990, Congress partially responded to this with the creation of the Family Unification Program (FUP) as part of the Affordable Housing Act of 1990. In 1991 the Congress included some limited appropriations that allowed a handful of states to draw-down these new targeted vouchers.

Thirty years later we are still facing a housing crisis both before and especially now after the pandemic and recession. While support programs including FUP are important tools, the nation needs a much more comprehensive housing strategy that reaches beyond child welfare.

In trying to implement the important new services provided under the Family First Prevention Services, caseworkers will, in many instances, need to address some of these overlapping services and needs of poverty, family violence and access to housing.

Child welfare cannot and should not be providing the funding for public housing but just as in the case of domestic violence services, housing needs will have to be coordinated for these families to successfully keep families together. Title IV-B programs can help to address these coordination and supplemental service that will help families address domestic violence and access to housing.

Additional funds and a specific category of family violence and access to housing services should be specified as part of the Title IV-B programs.

Recommendations

Short-Term

The new Administration should:

- Speed up the process of approval of new programs through the Title IV- E Prevention Services Clearinghouse.
- Encourage states to expand their use of the family preservation model, Homebuilders, since it has now become the first and only preservation model approved for use of Family First Services funding and encourage flexibility with the model by allowing it to serve other families including those in need of post-adoption services.
- Use CWS to help states address a range of COVID-19 problems including the need for more support for children and foster families in continuing their education at home and the need for more protective equipment for workers and families.

Long-Term

Congress and the new Administration should:

- Fully fund and reauthorize the Stephanie Tubbs-Jones Child Welfare Services (CWS) block grant to no less than the full authorization level of \$325 million. Use this already established flexible child welfare block grant in place of any waiver or block grant proposals. Include a new category of funding that can supplement child welfare agencies ability to address family violence and access to community housing services.
- Create a new set-aside or funding that can be used by states to better coordinate access to local housing needs and better coordination in addressing domestic and family violence issues for families within child welfare, especially those receiving Family First Prevention Services.
- Reauthorize and fully fund the Marylee Allen Promoting Safe and Stables program at no less than full funding at \$505 million.
- Allocate specific research funding that can be given to states, by formula or award, to help carry out the research that will demonstrate whether Family First Services are meeting the promising, supported or well-supported evidence based requirements.
- Reauthorize and increase the Court Improvement Program from \$30 million a year to \$60 million a year and fix the reauthorization problem that requires new cuts in spending just to maintain current level funding.

CHAPTER 4: Permanency for Children and Families Through Foster Care Reunification, Kinship Care, and Adoption

Foster Care and Strengthening Permanency

Foster Care

Foster care is an important support service for families and children with an ultimate goal that a child will be reunified with his or her family. According to AFCARS data in 2019, 55 percent of children were reunified with their family, 28 percent were adopted, and 7 percent were in kinship/guardianship care.⁶⁰ Knowing that majority of children are reunified with their parents means that foster “care” must always be a true system of care that helps children and strengthens families.

CWLA began in 1920 and our first major outcome study, “*How Foster Children Turn Out*” was published in 1924. Foster care existed long before the federal government engaged in its funding and regulation. In 1959, CWLA released the publication of a foundation-funded study, *Children in Need of Parents*. Authors took a closer look at 4,200 children out of an estimated 250,000

children in foster care and found that children were in care with “29 percent due to neglect/abandonment; 25 percent due to death, illness or economic hardship; 10 percent marital conflict; 9 percent unwed motherhood; 4 percent psychological problems; 24 percent other conditions.”⁶¹

Through the years federal and state policy and funding have grown but the mission has been the same, provide children with a temporary home while a permanent home was sought through reunification or another family.

The past ten years saw foster care placements reach more than a quarter century low when the number of children in foster care declined to 397,000 in 2012, well below the high of 564,000 in 1999. Despite this progress, the number of children in foster care began to increase in the middle of the last decade, with numbers peaking at 437,000 in 2017. Much of this increase was attributed to the latest drug epidemic, opioids, which had an impact in dozens of states. According to a 2018 report by HHS/ASPE: *“Although the experience of individual states varied, more than two-thirds (36 states) experienced caseload increases. Hardest hit have been six states whose foster care populations rose by more than 50 percent over this four-year period.”*⁶²

The marked increase in foster care numbers after nearly a 15-year decline highlights, once again, the role of substance abuse. That same research by HHS found that “a 10 percent increase in the overdose death rate corresponded to a 4.4 percent increase in the foster care entry rate. Similarly, a 10 percent increase in the average county’s drug-related hospitalization rate corresponded to a 2.9 percent increase in its foster care entry rate.”⁶³

By comparison, in March 1992, CWLA released a survey linking the drug epidemic to the 50 percent increase in foster care over the previous five years. The survey of several states and agencies found that of 305,716 children that were served in the previous year, 36.8 percent were from families in which there was an alcohol- or drug-abusing caregiver or were alcohol or drug abusers themselves. Private agencies and CPS workers indicated an even higher percentage.⁶⁴

As a result of the dramatic increases in foster care numbers in the late 1980s and 1990s, the Adoption and Safe Families Act (ASFA, P.L. 105-89) was enacted in 1997 to ensure safety and expedite permanency for children in the child welfare system. One of its primary missions was to ensure children did not remain in foster care for too long and that children ended up in permanent and safe families.

By 1999, 564,000 children were in foster care at the end of the federal fiscal year, a plurality of these children 38 percent or 215,000 were black children which exceeded the 34 percent or 192,780 white children. It was the clearest evidence yet that there was an overrepresentation of black children in the child welfare system but that was not necessarily a focus of the U.S. Congress.

ASFA

ASFA, today, is known mostly for its deadlines for termination of parental rights. States are to initiate termination of parental rights (TPR) in any case where the court has found that a parent has lost parental rights to that child’s sibling; killed another of his or her children or committed

felony assault against the child or a sibling, or subjected the child to aggravated circumstances; or for infants determined under state law to be abandoned. The original ASFA allowed states (under an ok by the governor or state legislature) to apply their own background check requirements for certain limited felony convictions if the state standard was as rigorous as the federal requirements. This option was eliminated in 2006 despite a dozen states using this standard that allowed greater use of relatives in placements. The law also requires initiating TPR proceedings for children who have been in foster care for *15 of the most recent 22 months*. This provision is what ASFA is most identified by many observers.

States can opt not to terminate parental rights if the child is in a relative's care, or if the state agency has documented in the child's case plan a compelling reason to determine that TPR would not be in the child's best interest, or if the state has not provided necessary services to the family. Ultimately it is a court's call and data on the overall number of terminations since ASFA is not clear.

ASFA however added many other features to the federal Title IV-B and Title IV-E laws. Federal law had required that all foster children have a judicial hearing within 18 months of their placement in care. That was changed to within 12 months of the date the child is determined to have entered care. As part of these changes foster parents, pre-adoptive parents, and relative caregivers are to be given notice and an opportunity to be heard at case reviews and permanency hearings.

Goals, which had included long-term foster care, were revised to include returning home, referral for adoption and termination of parental rights, guardianship, placement with a relative, or, as a last resort, another planned, permanent living arrangement—what some people now describe as APPLA or more recently OPPLA (other planned permanency living arrangement). HHS specified that states must document a compelling reason for APPLA and gave examples of these reasons: an older teen requests a plan of emancipation from foster care; a parent and child are strongly bonded but the parent cannot care for the child because of an emotional or physical disability and the child's foster parents have agreed to raise the child to maturity and to enable visits with the natural parent; or a tribe has identified APPLA for the child. This provision would come under greater limitations in the 2014 Preventing Sex Trafficking and Strengthening Families Act (PL 113-183) which limited APPLA as a permanency plan to youth age 16 and older.

As noted there is limited data on parental terminations since ASFA. A 2002 GAO report in 2002, just five years after enactment explained, *"HHS does not require states to collect this data. Survey data from a few states suggest that they use the fast track provision infrequently. Most of the states we visited reported using fast track for a small number of children, primarily those who have experienced serious abuse or whose parents previously had parental rights to other children terminated. However, state officials described several court-related issues, such as reluctance on the part of some judges to allow the state to bypass reunification efforts...survey responses from nine states indicated that they exempted a number of children—ranging from 31 to 2,919 in 2000...[states were] exempting many children, such as adolescents and children with serious medical needs for whom locating adoptive parents would take a long time. Other*

children exempted included those placed with relatives and those who were expected to reunify shortly with their families.”⁶⁵

As is the case with all child welfare law and practices, individual jurisdictions and states may present a very different view in practices and results for families and children.

ASFA created the first adoption incentives grants which was renamed in 2014 as the “Adoption and Legal Guardianship Incentive Payments.”⁶⁶ Last year, FY 2020, it was funded at \$75 million. Awards are based on the number of adoptions from foster care and now formalized kinship care permanency placements. Since 1997, the incentive has been modified several times in efforts to target certain populations of children waiting to be adopted, for example, older children and youth.

ASFA expanded the 1993 Family Preservation and Family Support program (Title IV-B part 2) to become the Promoting Safe and Stable Families Program with added funding that could also be used for adoption support and reunification funding, with set-asides for the courts relating to education of the courts on child welfare issues. The law also mandated expanded health insurance coverage for adopted children. Medicaid coverage was expanded to special needs adopted children with the law requiring states to provide health insurance coverage to these children if they have special needs for medical, mental health, or rehabilitative care. Because Title IV-E Adoption Assistance was still fully linked to the 1996 AFDC income eligibility requirements, this provision extended health care coverage to all special needs children, not just those eligible for Title IV-E funding.

The most positive and obvious outcome was an increase in the number of legalized adoptions. The annual number of adoptions increased by 57% between 1998 and 2001, with the numbers rising from 37,000 in 1998 to more than 50,000 in 2001 to 66,000 in 2019.¹⁰ These initial numbers were much larger than originally projected. Since that rapid increase in adoptions, the national numbers have remained above the range of 55,000 adoptions per year, with older children (over 8 years) representing a disproportionate share of children waiting to be adopted. In addition to promoting adoption, ASFA recognized kinship care as another option for providing children permanent families and moving them out of foster care but it did not provide funding for such placements. That did not happen until Congress enacted the 2008 Foster Connections to Success and Promoting Adoption ACT (PL 110-351) when states were given the option to extended the use of federal Title IV-E funds to subsidized guardianships with relative caregivers.

An emerging issue for needed reform is the issue of child support. States collect more than \$100 million a year in child support through the Title IV-E recoupment process. In the Obama Administration and in the last Congress proposals were raised to return or pass through some of these funds. This is a complex challenge since some funds may supplement state child welfare spending. It is also challenging since you do not want to recoup funds from a parent with a goal of reunification. There are other instances however, for example a young person transitioning to adulthood without a parent, whereby these funds could more directly help a child or youth. It is an area of greater need for solutions.

Reunification

Reunification is the first permanency option state and local child welfare agencies consider for children entering care. Yet, in many ways, it is the most challenging. In 2019, 55 percent or 226,724 children and youth had a case plan goal of reunification with their parents or other principal caretaker. In that same year, 47 percent (117,000) exited foster care to be reunified.

Successful permanency through reunification requires many things, including, at minimum, skilled caseworkers, readily available support and treatment resources, clear expectations and service plans, and excellent collaboration across involved agencies. National outcomes data generally indicates that approximately 8 percent of children re-enter foster within 12 months, but this data may not provide a full picture.⁶⁷

For example, in 2018 a review board in the state of Nebraska took a closer look at their foster care population. They noted that national Child and Family Services Review (CFSR) only measure re-entries for 12 months after the exit and so it does not capture later re-entries. (The revised AFCARS is expected to provide more long-term longitudinal lifetime data). The Nebraska review indicated that nearly one in four children in their current caseload had re-entered foster care at least once. Of the 534 entries, they determined that the median days from the last exit to the next re-entry was 19 months.

The reason for re-entry was similar to the reason for removal in the most recent re-entry: 76 percent removed for neglect the last time were removed for neglect the next time; 75 percent removed due to parental substance abuse were removed for parental substance abuse the next time and 57 percent removed due to domestic violence in the home were removed due to domestic violence the next time.

Despite the possibility of reducing the overall number of children in foster care by focusing resources on these reunified families at times of future need or relapse, we have focused almost no federal funding on such an important mission. The Family First Prevention Services Act may offer an avenue to support post-reunification services since states can define a child who has been reunified with his or her family as a “candidate for foster care” potentially offering that family follow up services that have not been federally funded in the past.⁶⁸

Foster Families

Foster families are a critical part of any permanency plan. A lack of foster families who can serve the range of needs that may include therapeutic care, homes that can serve sibling groups of children, homes willing to take in adolescents or teens, children with high medical needs or special needs are all critical. These “resource” families are facing multiple challenges from financial support, access to support services, and consultation with the courts and the family.

Foster families are an important factor in addressing the needs of children and youth under state custody. Yet, we do not have a sufficient pool of these caregivers. In many instances the lack of priority and supports make it difficult to recruit families to provide enough foster family care homes.

The Family First Prevention Services Act envisioned an increased state effort to find families as a result of new restrictions on the use of federal funding for certain types of residential care

(group homes) but a Congressional Budget Office calculation from 2016 found “*CBO estimates that about 70 percent of the children residing in group settings other than RTFs in 2020 would simply become ineligible for any reimbursement under title IV-E. By 2026, however, we expect states would increase the number of eligible foster parents and the percentage of children ineligible for reimbursement would decline to about 25 percent.*” Meaning there will still be a shortage of family foster care in 2026.

A growing number of children in out-of-home care require treatment services to meet their individual medical and behavioral needs. Some needs may be met by services such as day treatment, but for children in family foster care whose treatment needs would in years past have required group care or residential treatment, the services inherent in treatment foster care have become a critical component in a comprehensive service system. Treatment foster care, also known as therapeutic foster care, combines the benefits of the protection, support, and nurturing of a family foster care setting with the benefits of treatment services provided by specially trained, highly qualified, and intensively supervised foster parents.

Finding and supporting foster families to meet the needs of children has been a long-term challenge. In 1950, the New York Herald-Tribune described an effort by Queens College sociology students who visited 3,500 homes in a recruitment effort to address the shortage of foster homes. The effort resulted in hundreds of inquiries and 25 actual applicants. The results were considered a high percentage of responses.

In 1989, a GAO Report outlined the reasons for a shortage of foster parents: lack of respect from social service agencies, low foster parent reimbursement, limited respite for foster families, difficulty in liability insurance, insufficient training, and lack of access to agency social workers.⁶⁹

That same report described recruitment strategies in ways that are still just as relevant more than 30 years later: “*Recruiting themes should (1) present a realistic picture of the difficulties of caring for today’s foster children; (2) emphasize the temporary nature of foster care and the need for a working partnership with social service agencies; and (3) communicate a positive message about the role of foster parents. Foster parents are the most effective recruiters because they convey realistic expectations about foster care and can best answer potential foster parents’ questions.*”

The need exists to recruit more foster parents and provide greater support through better rates and more casework support. The 2007 report, *Hitting the M.A.R.C.*, documented a diversity of rates and methodology in setting those rates with national rates generally being 36 percent below what was calculated as needed to meet what was determined to be minimum adequate rates. Inadequate rates affect the ability to recruit and retain skilled families, likely increase financial stress, and directly affect the quality of care.⁷⁰

These problems remain and are not likely to be addressed without a comprehensive approach that make foster families feel supported because we have a system of care that provides support, education and training. Despite this need it is a fact that the federal funding source of Title IV-E foster care does not provide coverage to 60 percent of the children in foster care. In 2000, federal funds covered 51 percent (already in decline), but it has continued to decline due to the

fact that eligibility is still linked to the AFDC program as it existed in July 1996. The 2021 budget indicated that by 2019 this percentage decreased to 40 percent despite the five years of increases in the foster care population from 2012 to 2017 due to opioid addictions.⁷¹

This limited federal eligibility also means less than half the caseworkers are supported by federal funds. This adds to the workforce challenge, which ultimately leads to less support for foster families and children in foster care. It also undercuts the ability to recruit more foster families into to the system.

The AFDC link also means that the Children’s Bureau recent efforts to extend Title IV-E administrative funds to cover legal representation costs for parents is limited since coverage is based on the percentage of the caseload that is covered by Title IV-E foster care.⁷²

We need to lift up the image of these families and the children and youth who have experienced foster care. A recent survey by the Dave Thomas Foundation for Adoption⁷³ found that only 12 percent of adults were somewhat or very likely to consider being a foster parent. Other surveys have found negative perception regarding children and youth in care and foster parents. Ruth Massinga, Executive Director of Casey Family Programs, wrote in the Oakland Tribune in June 2004⁷⁴ : *“On any given day, on any given newsstand or television station, you can find a heartbreaking story about a child harmed while in foster care. These are inevitably followed by opinion pieces that categorically decry the child welfare system responsible for these terrible incidents. Between these periodic horror stories, the children and the many organizations that care for them are largely invisible to us, and we are left with the lingering impression that nothing good can come from the child welfare system.”*

The rhetoric by some advocacy groups likely doesn’t improve the circumstance when the public regularly is told or hears such clichés as “the foster care system is broken”, “we pay for foster care therefore we have foster care”. “foster care is a pipeline to prison”, or more new research is unveiled on the negative outcomes children and youth in foster care display. The rhetoric is unlikely to encourage the voting public or their elected representatives in Washington or state capitols to want to invest in quality care.

It is possible to have and espouse the dual important mission to ***both*** *reducing the number of children in foster care while also increasing the availability of quality foster care*. Fewer children in care means foster families are not pressed to care for more children than they have the capacity to care for while allowing us to invest in the quality of foster care for the fewer children that will need it.

Role of Courts in Permanency

Juvenile and family courts play an integral role in protecting children who have been abused or neglected. Through federal and state statutes, state courts are required to oversee the protection of children and ensure the child welfare agency meets reasonable efforts and permanency planning requirements. The state courts also must periodically review case plans of and service

delivery to children under their jurisdiction. To be effective, the courts must understand the dynamics of child abuse and neglect and the purpose of child protective services.

Juvenile and family courts are special statutory courts that, among other duties, adjudicate cases in which the child's need for protection by the state is at issue. These courts are protective in nature but judicial in function, bound by the rules of evidence, and inherently adversarial.

Juvenile and family courts should ensure the legal and constitutional rights of both parents and children are duly considered and protected and are presided over by a judge who has received specialized training in child welfare and juvenile matters and is specially assigned to hear such cases regularly. They also appoint specially trained guardians ad litem or CASAs to represent the best interests of the child, appoint attorneys for parents if they are unable to afford one, and protect the due process rights of all parties.

In best practice, the same judge hears all judicial matters related to the same child, including emergency placement, adjudication and disposition, foster care review, custody, and termination of parental rights. The judge also coordinates proceedings with those in other courts that involve the child under the jurisdiction of the court and minimize the trauma to a child who is involved in multiple court actions. The court can expedite custody and termination of parental rights hearings, where indicated, so the child can gain permanency.

Currently we provide approximately \$30 million a year to the state courts through the Court Improvement Program (CIP). Funds are allocated by formula to all states and tribal governments. These funds come through the Marylee Allen Promoting Safe and Stable Families program (Title IV-B, part 2). Funds are used by state courts for training, data collection, and other coordination. A set aside goes to tribal governments and consortia and so it can fluctuate depending on annual appropriations. \$20 million of the \$30 million is mandatory funding. Twenty million dollars in mandatory funds meaning that it does not require an annual appropriation, but it does require a reauthorization usually every five years. Due to the nature of the way the law was written, if Congress extends this \$20 million for a five-year period, then the Congress must find \$20 million a year in "new" spending revenue. That generally means Congress may cut in other areas (usually child welfare spending) just to maintain the same level of \$20 million a year.

Congress could fix this by extending funding beyond the five-year window and eliminate this unnecessary cut. In addition, the COVID-19 pandemic has shown more funding is needed with a doubling of funds to \$60 million. In good times more training and coordination are needed. In a pandemic when courts are shut down or go virtual, children and families are hurt when adoptions are delayed, reunifications do not take place, and child protection is hindered. As has been the case in other instances, the pandemic has demonstrated that some tools such a virtual appearance can be useful in future court interactions. Some child-youth meetings can be enhanced and increased but that is not always the case or the circumstance. We also need to be reminded that even without a pandemic more must be done to shorten times to reunifications, adoptions and relative placements.

Foster care is a critical service in the child welfare system for children and their families. As is the case in other parts of our nation's child welfare system, this one service cannot address all the challenges as we confront child abuse, neglect and other causes of out-of-home care. It represents one part of a comprehensive system of support, from prevention to early intervention services to reaching the goal of permanency for children, including reunification, adoption, or kinship care, along with the accompanying services and supports for each of these families.

Recommendations

Short-term

The new Administration should:

- Take lessons learned from the pandemic and promote their use. For example, a virtual meeting between a parent and age-appropriate child could become more frequent or a required parent court meeting could become more manageable for a parent that has work or travel constraints.
- Develop a national messaging strategy that can reshape public perceptions of foster parents and children in foster care. Use focus groups and polling to develop a long-term multi-media strategy to reshape attitudes. This effort must include re-casting how these children and families are described in entertainment, reporting and advocacy.

Congress and the new Administration should:

- Declare a month in honor of reunification, following the lead of at least some states, and consistent with April being Prevent Child Abuse Month; May, Foster Care Month; September, Kinship Care Month; and November, Adoption Month.
- Encourage states to use the new Family First Prevention Services funding to expand post-reunification support to families.

Long-term

Congress and the new Administration should:

- Eliminate the current eligibility link between Title IV-E foster care and 1996 AFDC eligibility standards. Federal eligibility should extend to all children in foster care. If covering all children at once is not possible, eligibility could be phased in, allowing full coverage based on the age of the child or when children enter care, similar to the phase-in of adoption assistance under the Fostering Connections Act. The de-link could be tied to certain minimum standards for family-based foster care.
- Eliminate the current eligibility link between Title IV-E foster care administrative costs from the 1996 AFDC eligibility standards. This will expand state's access to funds that can support the child welfare workforce. It also expands access to training funds for foster parents and expands access to funds for legal representation.

- Encourage new approaches to passing through child support collections to the family or young person, where appropriate.
- Encourage the use of Family First Prevention services that can be adapted to assist families through post-reunification services.
- Increase funds for the Court Improvement Program (CIP) to \$60 million annually and “fix” the mandatory language problem that requires cuts in other funds every 5 years.
- Require state plans to include a description of the methodology used to set foster care reimbursement rates and tie such requirements to a de-link of foster care funding from the AFDC eligibility link.

Kinship Care and Strengthening Permanency

Kinship Care

Kinship care is a situation in which an adult family member, such as a grandparent, aunt, uncle, or other relative, provides a caring home for a child who is not able to live with his or her parents. The practice of kin parenting children, when their parents cannot, is a time-honored tradition in most cultures and a primary and valuable permanency option. When children cannot safely remain with their biological parents, kinship parenting preserves children’s right to both a nurturing and loving family and connections with their family of origin, history and heritage. Kinship parenting provides a strong foundation upon which a loving, caring relationship has a firm footing and can flourish. Just as kinship caregivers step up for children, society must rally to ensure supports and services keep these families strong.

In the last century the practice was expanding so that CWLA began a process for developing policy and practice recommendations. In 1992, CWLA convened the North American Kinship Care Policy and Practice Committee. Through a series of meetings, the committee provided CWLA with expertise on the critical issues involved in kinship care.

CWLA published, *Kinship a Natural Bridge*⁷⁵, which summarized the thinking of the Committee and then initiated a demonstration project, “Enhanced Support Services for Kinship Caregiver Families.” As a result, CWLA convened the first national conference on kinship care. Colleagues in the field, including the members of the CWLA National Kinship Care Advisory Committee, urged CWLA to move forward with the development of best practice standards. The CWLA Kinship Care Best Practice Standards Committee met for the first time in October 1997 to begin the process of developing a new volume of kinship care standards.

The committee comprised individuals representing CWLA public and voluntary member agencies from various geographic regions of the country. The committee’s membership was ethnically and culturally diverse, and members encompassed the perspectives of agencies involved in kinship care as well as those of kinship caregivers. Other committee members represented national organizations concerned with kinship and related services, the National

Indian Child Welfare Association, the Council on Accreditation of Services for Families and Children, Inc., and the U.S. Department of Health and Human Services Children's Bureau.

Federal Action

By 1997, although the Adoption and Safe Families Act (ASFA) recognized placements with relatives or legal guardians as permanency options for children in foster care, the federal government failed to make funds available on a continuing basis to help those relatives care for the children. A few years earlier, in October 1979, the Supreme Court issued a significant 8-0 ruling (*Miller v. Youakim*) authored by Justice Thurgood Marshall regarding the use of kinship and relative care in foster care. To that point some states would not use AFDC-Foster Care for relative placements, limiting funding to non-relative foster care. They would use AFDC relative placements but that provided less assistance to the family. The opinion by Justice Marshall struck down that practice making clear relative foster care was permissible under federal law and the original Flemming rule.

After ASFA, since 1996 and until congressional action in 2008, some states had received federal funding through a Title IV-E child welfare waiver to provide support for guardians of children who have been in foster care previously. The waivers allowed states to use Title IV-E foster care funds for kinship and guardianship placements if states could provide the services without the federal government incurring any additional costs over a five-year period. States were (and are today) also relying on other sources of federal funding to support these placements, including TANF and SSBG.

A 2008 GAO report, *African American Children in Foster Care*,⁷⁶ examined the issue of the overrepresentation of black children in foster care and found that kinship care can be an important issue in addressing and reducing this disproportionality. The report said in part,

“Using subsidized guardianship as an alternative to adoption may hold particular promise for reducing disproportionality, and more than half of the states surveyed reported using this strategy. African American children are more likely than White children to be placed with relatives for foster care, which is generally a longer-term placement, and these relative caregivers are also more likely than nonrelative foster parents to be low income. They may be unwilling to adopt because they may find it difficult financially to forego foster care payments or because adoption entails terminating the parental rights of their kin. However, subsidized guardianship programs provide financial support for foster parents (often relatives) who agree to become legally responsible for children but are unable or willing to adopt.”

Reports like these and the experimentation with waivers allowing subsidized guardianships with relatives were big incentives for Congress to act on kinship care legislation. For several years, bipartisan legislation had been sponsored in both houses of Congress by prominent leaders including Senator Hillary Clinton (D-NY), Senator Olympia Snowe (R-ME), Congressman Danny Davis (D-IL) and Congressman Todd Platts (R-PA).

The same 2008 GAO report went on to highlight in remarks submitted to Congress, “*When Illinois and California implemented two of the largest of such programs, they subsequently saw an increase in permanent placements for all children. After instituting their subsidized guardianship programs, more than 40 percent of children who were in long-term relative foster care in both states found permanency. In Illinois, this decrease also coincided with a reduction in disproportionate numbers of African American children in foster care.*”⁷⁷

After many years of debate, Congress gave states the option to use federal Title IV-E funds for kinship guardianship payments for children raised by relative caregivers as part of the 2008 Fostering Connections to Success and Increasing Adoption Act (PL 110-351). If a state chooses to provide these subsidized guardianships to relative caregivers, the federal government will contribute funding just as it does for children placed in foster care. Children eligible, under this kinship option, must also be eligible for federal foster care maintenance payments, must reside with the relative for at least six consecutive months in foster care, and it must be determined that reunification is not possible, and adoption is not appropriate.

The ability of states to use this new Title IV-E option, combined with the use of TANF block grant funds for “child-only” grants that can assist relative caregivers caring with their relative children, without the need to have a child placed into state custody under the child welfare system, has allowed all fifty states to have some form of relative care. A majority of states use a combination of Title IV-E subsidized guardianship and TANF funded child-only grants. The TANF grants, however, tend to provide smaller monthly grants and TANF is not situated to provide casework and permanency support that should be available through Title IV-E guardianships. A recent GAO report found that in 2011 the national average for foster care maintenance payments for one child was \$511 versus \$249 per child under a TANF child-only grant.

Just as ASFA mandated background checks on all perspective families, it extended these background checks and prohibited placements to relative caregivers. In enacting this requirement, Congress had the insight to provide states with the ability to individualize their own eligibility requirements in this area and craft standards that in no way compromise the principle that a child’s safety is paramount. This so-called “opt out” flexibility allowed states to craft their own state laws and practices while maintaining the safety and health of children under their supervision. When originally enacted, the ASFA provision required that the “opt out” be requested by the Governor or state legislature to ensure that rigorously reviewed protections for children are implemented. As of 2006 the states of California, Colorado, Florida, Idaho, Massachusetts, Nebraska, New York, Ohio and Oklahoma had taken this option. In 2006 this option was eliminated by Congress for no obvious reason. It has meant some relatives, no matter how long ago their violation occurred, could not be eligible for a subsidized guardianship. Some states have utilized TANF child-only grants to support these appropriate relative caregiver placements despite TANF more limited support.⁷⁸

Today

July 2020, the Government Accountability Office (GAO) report examined relative caregivers’ issues in Child Welfare and Aging Programs. The report drew on data from child welfare (AFCARS) as well as two Census Bureau surveys.⁷⁹

This GAO report found that in 2018, among the general population, there were an estimated 2.7 million children that lived with kin caregivers— grandparents, other relatives, or close family friends, with 139,000 of those in formal foster care. The report found 38 percent of children were living with non-grandparent relatives and close friends.

The census data that was examined by the GAO showed a large population that is shifting in some ways. In regard to race in 2005, 50 percent of caregivers were white, with 25 percent black and 18 percent Hispanic. By 2018, those numbers had shifted somewhat to 53 percent white, 19 percent black, and nearly 20 percent Hispanic. Age was also moving, with the average age at 55 in 2005 rising to 59 by 2018. It also points to the significant share of these caregivers who are not elderly, with one-third of grandparents under the age of 55.

The report found substance abuse and incarceration as significant reasons for these living arrangements with up to 19 percent of relative placements due to a mother's substance abuse circumstance, 15 percent in the living arrangement due to a father's incarceration, and 7 percent due to a mother's incarceration. When the caregivers themselves were surveyed, it indicated an even bigger role for substance abuse. Relative caregivers said that alcohol or other drugs were a factor for 18 percent of mothers and 13 percent of fathers. Relatives surveyed said 7.3 percent of fathers were incarcerated while 14.7 percent of mothers were incarcerated. The different numbers were the result of the survey and the census data. Only 4.6 percent indicated that the child was in relative care due to child protective services (CPS) involvement by the mother while another 2 percent were being cared for due to the father's CPS involvement.

The needs of relative families include access to legal services (such as advice and help on obtaining legal decision-making), access to specific child services such as child care, help in school enrollment, and several other issues that challenge families. Another area was housing since some families have some obvious increased housing needs, or the change in status could raise housing arrangement issues that limit the presence of children. Families have limited options, and the report indicated that some of the federal barriers to helping families included the fact that many federal supports are either limited in funding or a state option.

When the GAO did their research, the subsidized guardianship state option under Title IV-E had been taken up by 33 states with an additional three states (Arkansas, North Carolina, and Oklahoma) having taken the option, but they were not serving families in 2019. More recent federal budget data for FY 2021 indicated that 38 states had taken the option to expand this relative care.⁸⁰

The GAO examined several support efforts, including kinship navigator programs. Kinship navigator funding was also part of some of the earlier kinship care legislation and a small amount of seed money was included into the Fostering Connections to Success Act of 2008 with at least \$5 million a year for competitive grants that would replicate earlier navigator efforts in states like New Jersey and Ohio. These resource and referral programs have always been intended to offer support to all relative caregivers by providing referrals to legal advice, support in accessing basic children's services such as child care and access to schools, as well as support groups for caregivers.

The funding of kinship navigators under the Fostering Connections to Success Act eventually dried up but Congress did allow new funding under the Family First Prevention Services Act if a state's program can meet one of the three tiers of evidenced-based proof of effectiveness.

As of the end of 2020, no kinship navigator program has met the lowest category of “promising” evidence-based standard under the Family First Clearinghouse, but in an assist by Congress to help promote the implementation of the Family First Prevention Services Act, Congress appropriated extra funds available to all states in 2018 and 2019 to help implement a kinship navigator program.

The Fostering Connections Act also includes several other improvements that have been a part of earlier kinship legislation. All states were required to have in place a notification process for relatives when a child comes into care. Notice is intended for relatives when the child has been or is being removed from the custody of his or her parents. Relatives are to be notified of the options the relative has to participate in the care and placement of the child, and the requirements to become a foster parent to the child.

According to an analysis by the Children's Bureau, agencies address these requirements through statute or regulation. The analysis indicated that preference for placement is given to the child's grandparents, although 12 states require that agencies must first determine whether a noncustodial parent is a suitable placement resource for the child. Other relatives considered for placement include great-grandparents, aunts, uncles, adult siblings, cousins, or the parent of the child's sibling. For Indian children, 11 states have statutes specifically allowing members of an Indian child's tribe to be considered “extended family members” for placement purposes.⁸¹

In 28 states and the District of Columbia, when a suitable relative cannot be found, the agency may consider placement with what some call “fictive kin,” a broad definition that generally includes close friends of the family or child and who has a substantial and positive relationship with the child. It is unclear how effective the notification has been over the past decade.

In the 2020 AFCARS report⁸² detailing child welfare data for 2019, 13,873 or three percent of children in care had a plan for placement with a relative. An additional 16,095 or four percent had a plan for guardianship. In the overall foster care population, relative foster parents totaled 32 percent of the overall foster care placements covering over 133,000 children.

The average monthly number of children for whom states receive guardianship assistance payments was approximately 38,000 in FY 2019.⁸³ The Administration has projected that number to increase to 46,300 children in federal FY 2021, although that projection was based on pre-pandemic conditions. The federal costs of these placements are projected to be approximately \$271 million in FY 2021. Subsidized relative guardianships, like foster care placements, are linked to the 1996 AFDC eligibility limitations.

Recommendations

Short-term

The new Administration should:

- Encourage and quicken the process, if needed, for states to extend Title IV-E funding to subsidized kinship programs if the remaining states need it.

Long-term

Congress and the new Administration should:

- Amend the state option under the 2008 Foster Connections to Success and Increasing Adoptions Act to require all fifty states to extend Title IV-E subsidized kinship care guardianship assistance program.
- Amend the Title IV-E subsidized kinship care guardianship assistance program by eliminating the six-month waiting period before a child in foster care can be permanently placed in a relative caregiver arrangement.
- De-link subsidized guardianships from the 1996 AFDC income standard.
- Restore the original Adoption and Safe Families Act (ASFA) state opt-out for appropriate background checks and placement decisions that recognize the best placements of children with a relative caregiver.
- Follow the progress and expansion of kinship navigator programs and if necessary, make adjustments to the evidence-based requirements under the Family First Prevention Services Act as it applies to navigator programs so that funding is made available.
- Reauthorize TANF funding with an increase in the block grant from its fixed 1996 level so that the current erosion in TANF funds will not result in states choosing between basic cash assistance to support keeping families together versus child-only kinship grants.
- Require state notification by the TANF agency that a family may have an option to pursue a subsidized guardianship through the Title IV-E (child welfare) agency.

Strengthening Adoptions from the Child Welfare System

Adoption History

Adoption has long been a vital service for children who need families, bringing children whose birth parents cannot or will not be able to provide for them together with nurturing adults who seek to build or add to their families. Around 4 million babies are born in the United States each year. According to the Adoption Network statistics, around 140,000 children are adopted by American families each year, and with approximately 62 percent of babies in domestic infant adoptions placed with their adoptive families within a month of birth.

Of non-stepparent adoptions, about 59 percent are from child welfare (foster care), 26 percent are from other countries, and 15 percent are voluntarily relinquished American babies.⁸⁴ Past surveys indicate 47% of adults have been touched by adoption in some way.⁸⁵

Since the second half of the twentieth century, families choosing to adopt have become increasingly diverse. A growing number of foster families, families of color, older individuals, families with children, two-parent working families, single parents (both male and female), gay and lesbian couples, families with modest incomes, individuals with physical disabilities, and families of all education levels, religious persuasions, and from all parts of the country now adopt. These individuals and families have one important characteristic in common, however: They are willing and able to make a lifelong commitment to protect and nurture a child not born to them by providing that child a safe and loving family. That is important because there are more than 120,000 in foster care waiting for a family.

CWLA published the first professional standards to guide adoption agencies in 1938. The “Minimum Safeguards in Adoption,” was adopted by the Board on November 5, 1938. The standards revolve around three principles: I. The safeguards that the child should be given; II. The safeguards that the adopting family should expect; III. The safeguards that the state should require for its own and the child’s protection.

By 1955 a CWLA study of adoption culminated in a national conference on adoption in Chicago. CWLA announced that the era of special needs adoption had arrived. Later that year, the Ittleson Foundation provided a three-year grant to set up permanent standards that would be supplemented as needed, would have periodic revisions, and would build clues for basic research. The first such standards would be Standards for Adoption Services in 1958.

Federal Action

In 1958, CWLA agreed to a contract with the Bureau of Indian Affairs to facilitate the adoption of Indian children by white families and the project started operating in fourteen reservations in six states: Arizona, Montana, Nevada, North Carolina, South Dakota and Wyoming. The contract and the practice built a long-time U.S. history of forced separation of Indian children from their communities and cultures. In 2001 at a conference by the National Indian Child Welfare Association, CWLA offered a formal apology for its role with these past federal actions and policies.

In 1978, the first major piece of federal legislation was enacted, the Adoption Opportunities Act. Through the years since, this Act has promoted, through grants and research, better recruitment practices that promote the adoption with an emphasis on minority children. The 1978 Act would also create a national working group to write the first model adoption legislation for state governments to enact.

That model adoption legislation would be published in the federal register at approximately the same time the Congress was debating what would become the Adoption Assistance and Child Welfare Act (PL 96-272). During House testimony on the state legislative standards for adoption law, CWLA representatives expressed concerns about the legislation- heavy emphasis on infant adoptions, a lack of guidance to states on reimbursing agencies for the full costs, and

several other provisions. The House Education and Labor Committee also received testimony from Sydney Duncan, Executive Director of Homes for Black Children, Detroit, Michigan, who testified that estimates suggested that there were 500,000 children available for adoption across the country “with a disproportionate number being Black, handicapped or older.”

Funding provided for Adoption Opportunities is administered by HHS and is distributed through competitive grants and contracts. The program provides grants to address post-adoption services, the recruitment of minority families, and the adoption of older children. Programs such as AdoptUSKids are a national example of some of the programs funded through Adoption Opportunities.

Adoptions receive a major boost because of the 1980 creation of Adoption Assistance payments through the creation of a new Title IV-E of the Social Security Act (PL 96-272). New entitlement funds would be available for families that adopted from foster care. The next biggest federal action to promote adoptions would take place in 1997 when ASFA sought to increase the level of adoptions from foster care.

CWLA’s adoption focus has been on the adoption of children from foster care. More than 122, 216 children in the child welfare system are classified as “waiting to be adopted” in 2019. A total of 71,000 of these children have had parental rights terminated. In some states, the process may not mean immediate termination of parental rights even though the state has determined that the child cannot be reunified with the birth parents and the route to permanency is adoption.⁸⁶

Of the children waiting to be adopted from foster care, a disproportionate number are from minority populations. National statistics from the most recent year, 2019: 22% were black non-Hispanic, 44% were white non-Hispanic, 22% were Hispanic, 8% were mixed race non-Hispanic, 2% were Native American or Alaska Native non-Hispanic.⁸⁷ This disproportionality or over-representation of certain ethnic or racial groups can be more pronounced in certain parts of the country. For example, a state with a greater Native American population will show greater disproportionality than the national data indicates.

Permanency through Adoption

The Title IV-E Adoption Assistance program is the primary federal support for adopting children from foster care, as it provides subsidies to eligible families who adopt children with special needs (as defined by the state) from the foster care system. In FY 2021, the federal government will provide a projected \$3.8 billion for adoption assistance payments, services, and administrative costs associated with placing children in adoptive homes. A projected 649,400 children will be helped by adoption assistance-related federal funding in FY 2021, which is a projected increase from last year’s projection of 523,000 for the current FY 2020.⁸⁸

The 2008 Fostering Connections to Success Act gradually phased out the Title IV-E Adoption Assistance link to the outdated 1996 AFDC eligibility standards. If a child was removed from a home that would have been eligible for AFDC as it existed on July 16, 1996, that child’s adoptive family may be eligible for special-needs adoption assistance and the federal government would subsidize part of that adoption assistance. Congress changed this requirement so that it would be phased out over ten years. Eligibility would be tied to a child being a “special needs”

(usually from foster care) child. Each year a younger group of special needs adopted children would be delinked from AFDC. The phase-out was nearly complete but was frozen in 2018 as part of the Family First Prevention Services Act so that the link remains in place through June 2024 for children under age two. The continued link was inserted as a way to help offset some of the costs of the new Family First Prevention Services Act.

As part of the de-link from 2009 through 2018, states were directed to take any state savings from the expanded federal adoption assistance and reinvest the state savings into child welfare services. If a state generates any savings in state dollars due to broader federal support for special-needs adoptions, that state must reinvest it in Title IV-B child welfare services.

By federal year 2017, states had saved \$149 million in that year alone.⁸⁹ HHS had been posting state savings each year but the Family First Prevention Services Act directs the GAO to study the issue and the savings generated and whether states are reinvesting the funds.

Adoption Incentives is another adoption funding source first enacted as part of ASFA in 1997 to promote greater permanence for children. The incentive fund is under Title IV-E. If states increase the number of children adopted from foster care over a previous year's high mark, they are awarded an incentive from this appropriation. Congress reauthorized the Incentive Fund as part of the Title IV-B programs in February 2018 as part of the Families First Act.

Over the years Congress has modified the incentive fund by adjusting the targeting of certain population of children, such as older children with a higher formula based on children adopted from this age group. In 2014 Congress again made modifications to the incentive fund by extending it to some kinship placements and renaming it the Adoption and Legal Guardianship Incentive Payments. It now awards incentives based on increases in either adoptions and subsidized/kinship guardianship placements. The formula is also based on the rate of adoptions rather than a fixed number of adoptions. This adjustment rewards states that have a decreasing population of children in foster care but states that still make progress in placing these children for adoption. Funds are reinvested into child welfare and adoption support services.

November 2013 saw the launch of the National Electronic Interstate Compact Enterprise (NEICE) with funding from the Office of Management and Budget through the Partnership Fund for Program Integrity Innovation. The NEICE is an electronic, data transmittal system for children and youth in interstate cases of foster care. The system helps alleviate state, administrative loads and, most importantly, decreases the time a child is waiting for state action to assist their welfare. The pilot projects reduced placement times sometimes by many months. These same needs exist for all children in state, foster care- and, those adopted from state, foster care.

In 2018 Congress provided a set-aside of Title IV-B funds to implement NEICE nationwide. Funding was allocated as part of the Family First Act, but to hold down budget scoring costs (the CBO calculation of cost), the implementation was spread out over a ten-year period. The law requires states to join the national electronic interstate system for processing Interstate Compact on the Placement of Children (ICPC) cases by 2027. Currently there are 34 states that are using NEICE. It is unnecessary to make children wait. Moving up this requirement would result in

states more quickly implementing this electronic system, which will potentially increase the permanency options for children and help them exit foster care more quickly.

The Interstate Compact on Adoption and Medical Assistance (ICAMA) was created in 1986 to transfer adoption, case information across state lines. It is the sister compact to the ICPC and is operated and overseen by its separate administrators, the Association of Administrators to the ICAMA—(AAICAMA.) The Compact is charged with securing and ensuring the benefits for children adopted with special needs are entitled and as required under federal law.

The ICAMA is the mechanism that ensures that the vital service of Medicaid is received in and across states by children with special needs. The value of Medicaid to this population of children cannot be overstated and the value of the Compact that ensures the receipt of Medicaid interstate is similarly invaluable. The ICAMA created a uniform system of forms, protocols, and practices to be used by the Association's network of state, interstate staff to open and close Medicaid cases. This enabled children with Adoption Assistance to receive Medicaid from the state in which they lived. Similar to the ICPC, this Compact began by using Postal Service to transmit case information. However, the use of the mail system to deliver interstate, child welfare information was slow and unreliable. It caused unnecessary and potentially harmful delays in the delivering of child welfare benefits.

The ICPC addressed this with NEICE, however, no similar construct or assistance was given to the ICAMA to meet the needs of the youth under its Compact. The ICAMA was not made a partner in the NEICE project and the same youth that have come through the ICPC and/or receive title IV-E funding do not have the benefit of the federal support and funding afforded to the ICPC.

In 2015, after many years of development, the AAICAMA created, funded, and launched its own, electronic system of data transmission to ensure that its federal mandate to protect the interests of children adopted with special needs was met. Known as the ICAMA System, it is supported entirely by state funds and used to open and close Medicaid cases. It ensures that children with special needs receive the medical assistance vital to their health and wellbeing and upholds the directive of federal law to preserve the interests of these children interstate

In 2019, the median age of children waiting to be adopted was 7.7 years. That represents an increase from ten years earlier when in 2009 the median age for children waiting to be adopted was 4.1 years. Last year (FY 2020) it was funded at \$75 million. In recent years, Congress has appropriated additional funds to make up for a shortfall in federal funds that shrank states awards across the board.

As indicated, the oldest federal program promoting adoptions is the Adoption Opportunities Program. Funding is distributed through competitive grants and contracts. The program provides grants to address post-adoption services, the recruitment of minority families, and the adoption of older children. Programs such as AdoptUSKids are a national example of some of the programs funded through Adoption Opportunities. Funds, at times, have been diverted to non-adoption programs and research. The Adoption Opportunities Program was funded at \$42 million in 2020.

Adoption Challenges in 2021: Post Adoption Support

As time passes and adoptive families increase, there is a corresponding need to address, through post-adoption services, some of the challenges that may surface in later years for these families. The most common post-adoption services include support groups, crisis intervention, child and family advocacy, adoption searches, case management, family therapy, mental health treatment, respite care, and targeted case management. Some adoption agencies also provide chemical abuse treatment, day treatment, and intensive in-home supervision, indicating a strong commitment to making adoption placements work.

Funding for these important services has been drawn from a mix of federal, state, local, and private agency efforts, and private funds. It remains a need. It is hoped that at least part of this need can be addressed by the new Family First Prevention Services Act. States may use prevention services for a family that has adopted from foster care. This can be done by classifying a family that adopts from foster care (or international adoptions) as a “candidate for foster care”, thus opening up potential services. These services would have to meet one of the evidence-based standards as outlined in new law.

A second potential source for much needed post-adoption services was provided through the 2014 Strengthening Families and Preventing Sex Trafficking Act, which strengthened the requirement that states reinvest savings from the federal expansion of the 2008 adoption assistance de-link. That act included a requirement that states spend at least 20 percent of the funds saved through the adoption assistance delink to provide post-adoption and post-guardianship support services, but the momentum on this has been stalled with the 2018 delay in the phase-out of the de-link.⁹⁰

Adoption Equity Issues

The year of 2020 has revealed the ensuing debate over racial equity, adoption issues cannot be raised without highlighting the debate over the 1994 Multi-Ethnic Placement act (MEPA).

The Multiethnic Placement Act (MEPA) was passed in 1994. The debate in 1994 was that children were being denied placements due to an over reliance on policies that took into account the racial and ethnic makeup of the prospective adoptive family. MEPA prohibited placement and recruitment decisions based solely on race, color, or national origin and required diligent efforts to expand the number of racially and ethnically diverse foster and adoptive parents. MEPA also amended the title IV-B state plan requirements to require states to provide for the diligent recruitment of potential foster and adoptive families that reflect the ethnic and racial diversity of children who need homes.

MEPA was amended two years later in 1996 and became “IEPA” (interethnic placement act) to clarify its intent by removing the word, “solely.” Congress made the requirements stricter not just by narrowing the consideration of race, but also created two new penalties targeting the child welfare agency and the private agency that may be providing the services.

In 2003, the Bush administration released a memorandum that made it difficult for agencies to assess families' ability to meet a child's racial and cultural needs and deterred many agencies from even training families about race: "State child welfare agencies...must ensure that they do not take action that deters families from pursuing foster care or adoption across lines of race, color, or national origin. Whether subtle or direct, [such] efforts...cannot be tolerated. CWLA firmly believes the best interest of the child must be paramount in any decisions that surround placement and services."

Despite the diligent recruitment requirements placed on states, it is unclear how much impact this Title IV-B plan requirement has had. It is also unclear whether Adoption Opportunities funding has had been targeted toward minority recruitment priority even though it is one of the main priorities for that funding program.

Research conducted by the Office of the Assistant Secretary for Planning and Evaluation (ASPE) in 2020 analyzed states Diligent Recruitment Plans (DRPs) and found that the 2018 CFSRs rated 34 states diligent recruitment efforts as "needing improvement," and 16 states receiving a rating of "strength." Per MEPA's requirements, states DRPs contains eight elements to help them develop and implement a comprehensive plan to increase the pool of and recruit diverse foster and adoptive parents. "In states DRPs, the common areas for missing information were in four elements:

- strategies for ensuring that people know how they can become a foster or adoptive parent if they are interested;
- strategies for training staff to work with diverse cultural, racial, and economic communities;
- strategies for dealing with linguistic barriers; and
- nondiscriminatory fee structures."⁹¹

The CWLA *Standards of Excellence for Adoption Services* highlight certain key principles, including:

When consistent with the child's best interest, the agency providing adoption services should honor the birth parents' request that a family of the same race or ethnic background adopt the child. The child's adoption, however, should not be denied or delayed if the agency is unable to recruit adoptive parents of the child's race or culture and adoptive parents of other cultural or racial groups are available.

All children deserve to be raised in a family that respects their cultural heritage.

In any adoption plan, the best interests of the child should be paramount.

All decisions should be based on the needs of the individual child. If aggressive, ongoing recruitment efforts are unsuccessful in finding families of the same race or culture as the child, other families should be considered to ensure the child's adoptive placement is not delayed.

Assessment and preparation of a child for a transracial/transcultural adoption should recognize the importance of culture and race to the child and his or her experiences and identifications. The

adoptive family should demonstrate an awareness of and sensitivity to the cultural resources that may be needed after placement.

Adoption Challenges in 2021: LGBTQ Children, Youth and Families

Nothing has drawn more controversy over the past four years than the way we have dealt with issue of gender and sexual equity. The current administration has made numerous attempts to discriminate against the LGBTQ community, arguing that it is merely an effort to promote religious freedom.

The Child Welfare League of America enters its second century in 2021. Throughout that history, our membership has included many private and faith-based agencies, as well as public agencies, all in service to these children and their families. We, and all of our member organizations, have changed with the times. There are practices and standards that existed in 1920 that would simply be inappropriate today, even if they were well-intentioned or based on what we knew then.

One factor that has been consistent for the past 100 years is the fact that those agencies always sought, and do seek, to place children first. Placing children first, and their “best interests” first has meant changing from past practices.

Over time, we have benefited from scientific advancement that has led to a better understanding of brain development; a better understanding of child and youth development; and an always evolving societal and political history that has resulted in cultural, racial, ethnic and religious changes. These changes, in many instances, involved the rejection of prejudice and practice based on racial, ethnic, religious, and tribal differences. Rejection of these prejudices have made us stronger as a nation and has allowed us to place the primacy of children and youth first.

The “best interests” of children, as written into federal law under Title IV-B and Title IV-E of the Social Security Act, cannot be served if we turn this into a political fight that is more about which providers receive federal money and who can win the votes while children wait for their best interests to be served.

CWLA’s history includes our efforts in support of LGBTQ children, youth, and families by working in partnership with Lambda Legal, the nation’s oldest and largest civil rights organization dedicated to supporting LGBTQ people, as well as people with HIV or AIDS. In 2002 CWLA and Lambda Legal created an initiative entitled Fostering Transitions: CWLA/Lambda Joint Initiative to Support LGBTQ youth and Adults Involved with the Child Welfare System. The goal was to increase the child welfare system’s capacity to meet the needs of lesbian, gay, bisexual, transgender and questioning (LGBTQ) children, youth, adults, and families.

We support making decisions about approving prospective parents and matching waiting children on a case-by-case basis, based on the strengths of the family, safety of the home, and the best interests of each child. Based on more than three decades of social science research, we believe that families with LGBT members deserve the same rights and levels of support afforded

other families. Any attempt to preclude or prevent LGBT individuals or couples from parenting based solely on their sexual orientation or gender identity is not in the best interest of children. Scientific evidence demonstrates that children who grow up with one or two parents who are gay or lesbian fare as well in emotional, cognitive, social, and sexual functioning as do children whose parents are heterosexual.⁹²

According to the 2020 AFCARS report, there are 423,000 children in foster care. According to the same report, there are just over 122,000 children awaiting an adoptive family. In that same year, 20,000 youth aged out of foster care into adulthood without a family.⁹³

When states bar eligible, qualified families from fostering or adopting children based on religion or because they belong to the LGBTQ community, they significantly restrict the pool of families for children. When states contract for services that restrict access based on religious preference, children and youth will suffer. This is particularly concerning for LGBTQ foster or adopted youth. LGBTQ youth are at high risk of suicide and often need critical mental and physical health and other supportive services.

To restate what we have said many times before, based on a preponderance of existing research substantiating the ability of gay, lesbian, and bisexual adults to serve as competent, caring, supportive and loving parents, and consistent with the Standards of Excellence for Child Welfare Services, CWLA commits its experience, its resources, and its influence to supporting LGBTQ children, youth, adults, and families involved in America's child welfare system. Congress and the Administration needs to enact legislation that will make it clear that discrimination on the basis of gender, sex or sexual preference is not in the best interest of children or society.

Recommendations

Short-term

The new Administration should:

- Reinstate the protections that were repealed in November 2019 that prohibited discrimination within programs under the jurisdiction of the Department of Health and Human Services.
- Suspend waivers issued by the Administration that allowing for discrimination in recruitment and placement within the child welfare system.
- Encourage states to include adoptive families in their service plans that target Family First Prevention Services.
- Publish the number of adoption assistance claims and the subsidized guardianship annual numbers in the annual AFCARS reports.
- Clarify guidance through the Children Welfare Policy Manual under the Multi-Ethnic Placement Act (MEPA/IEPA). The guidance provides little information about the specific recruitment of families of color. New guidance is needed to put a priority on

recruiting prospective families as diverse as the children in care.

Long-term

Congress and the new Administration should:

- Reauthorize and increase funding to the Adoption Opportunities program and place a greater emphasis on spending appropriated dollars on proposals and programs that will extend post-adoption services and advance the recruitment of minority parents.
- Re-insert the original language under the 1994 Multi-Ethnic Placement Act including re-inserting the word “solely” into MEPA and issue new guidance that allows agencies to have open conversations with prospective foster and adoptive parents about the possibility of bringing a child into their home from a different race and/or ethnicity allowing families who decide to move forward with this decision to receive the training and support that is needed to ensure that they can provide the children with all that they need to develop into healthy, functioning adults.
- Re-visit the requirements under the 2008 Foster Connections to Success Act that requires states to re-invest saving from the adoption assistance de-link into child welfare services and specify that a significant percentage of these savings be designated for “post-adoption” services.
- Increase the speed of implementation of the new National Electronic Interstate Compact Enterprise (NEICE) program to effectively and timely serve children in crisis. Suggested date of 2023.
- Fund a project similar to the NEICE project to protect the rights of youth adopted with special needs as mandated in federal law by supporting the Interstate Compact on Adoption and Medical Assistance’s existing, interstate, electronic, case management and transmittal system (the ICAMA System). This will extend the same support and electronic services provided to children and youth in foster care through the Interstate Compact on the Placement of Children (ICPC) to children and youth in adoption through the interstate compact that serves this population- the Interstate Compact on Adoption and Medical Assistance (ICAMA.)
- Restore the phase-out of the adoption assistance de-link so that it takes place next year instead of 2024.
- Pass legislation that would ban discrimination in placement and recruitment decisions by any agencies that receive federal title IV-E and Title IV-B funding.
- Pass legislation that makes the current adoption tax credit fully refundable

K-12 Education and Children in Care

Schools should serve as a source of stability for a child in foster care. A child placed in foster care may have to move to a new environment which can mean the child has to adjust to a new home, neighborhood, as well as a new school. A new school may mean a delay in enrollment because of required health and immunization records, and grades may not be readily available. A school transfer may take place in the middle of a school year, disrupting a foster child's classes and breaking relationships with teachers, friends, and other peers, which adds to the level of stress. A foster child leaving these attachments behind will also be confronting the stresses of new teachers, friends, and curricula.

Although some foster children may be best served by remaining in the same school despite being moved out of that district, this in fact may not always be an option for the child and foster parent. This option may exist in other instances, but services that would make this possible, such as bus transportation or covering the cost of individual transportation, are not available.

In 2008, Congress accessed information that youth in foster care in some states had been moved through an average of nine different schools during their tenure in foster care and that children and youth were commonly out of school for weeks or months on end. Congress mandated new requirements on state child welfare agencies. In 2008, the Fostering Connections to Success Act mandated certain protections for children and youth in foster care: maintain attendance at a child's school of origin if that is practical and physically possible; if a new school is required, provide for immediate enrollment and transfer of records; allow for certain coverage of education (including transportation) costs.

The immediate challenge after the 2008 legislation was that the same requirements were not placed on the state and local education agencies. In 2015, President Obama signed into law the Every Student Succeeds Act (ESSA). It reauthorized the Elementary and Secondary Education Act (ESEA) along with provisions to require state education agencies to ensure protections for vulnerable children and youth in the foster care and juvenile justice systems. These include school stability and transportation, mandatory data reporting, and agency collaboration.

Education for all children is fundamental to a successful future. It is perhaps even more critical to those children who at a young age face additional life challenges. That is why access to a quality education and ongoing support and encouragement are so vital to the approximate 600,000 children who will spend time in foster care in a given year.

The COVID-19 pandemic has highlighted some of the ongoing challenges in providing education stability for children and youth in foster care. There was still a challenge of coordination and oversight between the two agencies (child welfare/education) before the pandemic, but now with remote learning, the need for foster parents to become teachers, the part of the student body (foster children) with special education needs, the need for technology, internet and software services were all felt even more in these families providing foster care in a pandemic.

The ESSA requires each state education agency (SEA) to include in the education plan it submits to the federal government the steps it will take to ensure collaboration with the state child welfare agency to ensure educational stability for students in foster care. As part of this

responsibility, every SEA must designate an employee to serve as a “point of contact” (POC) for foster care. The state level POC is responsible for ensuring that there is collaboration with the state child welfare agency. The state POC should assist with the development of joint state guidance or an interagency agreement that could clarify how the state will support local educational agencies’ (LEA) development of transportation plans or their appointment of school-based POCs.⁹⁴

ESSA requires each local educational agency (LEA) in every state to provide assurances that the agency will collaborate with the state or local child welfare agency to designate a POC *if the corresponding* child welfare agency notifies the LEA in writing that the child welfare agency has designated an employee to serve as a POC for the LEA. In other words there are LOC’s for both the child welfare agency and the local education agency. The best way to increase the odds of education coordination for children and youth in foster care.

Even before the pandemic, state and local child welfare agencies did not necessarily have points of contact (POCs) like the education agencies provide. The pandemic and recession have made the education challenges for children in foster care even greater. All families have been challenged in addressing education needs due to the need to learn remotely or be out of school. Remote learning means internet access and the computer equipment and software that allows student to continue their education. In addition to the challenge’s families have, some remote communities may lack internet services.

For foster families and the children they care for, they may have had limited incomes before the pandemic, as well as limited access to computers and internet services. Many children and youth in foster care may have special and additional education needs, they may have fallen behind before the pandemic, and now, with limited access to education services provided in a school setting, school closings or virtual schools may limit access to such education supports.

Congress needs to follow up on the reforms of the past 12 years with additional oversight through both child welfare and education law through a GAO report that could focus on: cross agency collaboration at all levels including federal, state and local governments; an examination of data sharing at all levels of government; and specific to this time period and the impact on vulnerable student populations including students in foster care.

We also need to look at new requirements for the courts to identify education decisionmakers in case plan and court hearings. This can be a challenge depending on the nature of the placement. Is the parent the decision maker or the foster parent? This is highlighted in this pandemic as the foster parent may face the potential health risk. The court also needs to require and document education stability and success at permanency hearings and in the case reviews.

Recommendations

Short-Term

The new Administration should:

- If Congress provides more funds through the title IV-B child welfare programs as a result of the pandemic, guidance to states on how to provide vital education supports for foster parents and students including the use and access to important technology.

Long-Term

Congress and the new Administration should

- Establish a formula grant program which provides allocated dollars to State Education Agencies to distribute to Local Education Agencies to support students in foster care. Funding can be used for staff as well as transportation.
- Prioritize students in foster care with some additional funding to states to support statewide and local funding for K-12 education to help students and families with educational activities including tutoring, purchase of equipment, and additional services related to education.
- Require Education Points of Contact (POCs) in State and Local CW Agencies--- to be a parallel to the POCs at SEAs and LEAs. Many states already have these staff in place as they are required to trigger LEAs to have a POC. But ESSA requires them for SEAs and LEAs (with that trigger) and there is no similar requirement for CWAs.
- Require the court to document education stability and success at permanency hearings and in the case reviews and identify the education decision maker.
- Increase the John H. Chafee Foster Care Program for Successful Transition to Adulthood (Chafee) by \$500 million and the John H. Chafee Educational and Training Vouchers Program for Youths Aging out of Foster Care (Chafee ETV) by \$50 million. Also, increase the maximum Chafee ETV award amount from \$5,000 up to \$12,000 per youth per year for training and postsecondary education for eligible foster youth and raise the maximum age through 26 for Chafee-eligible former foster youth.

CHAPTER 5: Helping Young People

Youth Transitioning Out of Foster Care

Certainly, there are few groups more deserving of Congress' attention than those in foster care or who leave foster care after turning 18. In 2019, 20,445 young people exited the foster care system without a permanent family through reunification, adoption or placement with a relative.⁹⁵ In the past decade this number has exceeded 29,000 youth.⁹⁶ These young people

leave care simply because there is an age limit on federal funding. Although some states extend this support beyond age 18, and the John H. Chafee Independent Living Program for Successful Transition to Adulthood offers limited funding for transitional services to these young people to age 23, all too often the end result is that young people in foster care find themselves on their own at 18.

Adolescents in foster care are at higher risk for continuing medical problems, which are exacerbated by multiple placements, lack of continuity of intervention and recordkeeping, and declining emphasis on preventive measures, such as immunizations, as they enter adolescence. Adolescents in foster care report low levels of trust in adults and the service system, which may prevent their accessing health care and other services.

Immediately following statutory discharge from the foster care system, many young people may experience tremendous problems both in terms of their health status and in their ability to access health services. Because health coverage may end at the time of emancipation, young people lose both routine preventive care and the care they need to treat chronic medical conditions.

Securing and maintaining employment are critical factors in achieving self-sufficiency in early adulthood. Youth who must leave foster care at age 18 often are still in high school. If they have been able to secure employment at all, most are still in entry-level positions.⁹⁷ Clearly, the realities of educational underachievement and difficulties securing and maintaining employment place these youth at a significant disadvantage for meeting their health needs, achieving economic self-sufficiency, and maintaining long-term well-being.

Young people exiting foster care are at greater risk for homelessness than are youth in general. In New York, for example, research found that half of the homeless young people who came to shelters had previously lived in a foster home, a group home, or other setting provided by the child welfare system.

Adolescents constitute a major segment of the youth in the child welfare system. The ultimate goal is to prevent any child or young person from reaching a point of transition to adulthood. Every child and youth should ultimately have a permanent family.

Over the past ten years we have made progress but there is much more to do. In 2005, 29% of children in care were age 15 years older.⁹⁸ By 2019 this percentage had decreased to 17 percent for youth in foster care age 15 through 19. Most youth enter out-of-home care as a result of abuse, neglect, or exploitation. A new survey in New York City indicated that more than one out of three young people (34.1%), ages 13-20, in the city's foster care system identify as LGBTQAI+, a substantially higher than the proportion of LGBTQAI+ youth in the general population.⁹⁹ Others have run away from home or have no homes. Young people transitioning out of foster care are affected significantly by the instability that accompanies long periods of out-of-home placement during childhood and adolescence. They often find themselves truly on their own, with few if any financial resources, no place to live, and little or no support from family, friends, or community. Their experiences place them at higher risk for unemployment, poor educational outcomes, health issues, early parenthood, long-term dependency on public

assistance, increased rates of incarceration, and homelessness. The resulting harm to the youth themselves, their communities, and society at large is unacceptably high.

Federal support for independent living services for foster youth began in 1986 when Title IV-E was amended to include the Independent Living Program to help youth who would eventually be emancipated from foster care. In 1993, Congress permanently extended the authority for the Independent Living Program. Passage of the Chafee Foster Care Independence Program in 1999 significantly improved previous versions. The law allowed states to extend Medicaid coverage to former foster children ages 18–21 (see ACA provisions below); funding was doubled to \$140 million per year in 2001.

The improvements in the Chafee Foster Care Independence Program helps states provide services to young people as they age out of foster care. The program helps eligible children make the transition to self-sufficiency through such services as assistance in earning a high school diploma, support in career exploration, vocational training, job placement and retention, and training in daily living skills. In addition to the Medicaid coverage, the program allows up to 30% of funds to be used for room and board.

In 2001, Congress authorized an additional \$60 million in discretionary funds for education and training vouchers for youth eligible for the Foster Care Independence Program, as well as youth adopted from foster care after age 16. The Education and Training Vouchers (ETV) program provides assistance of up to \$5,000 per year for the cost of attending an institution of higher education for youth who age out of foster care or are adopted after age 16. Funding for this program has never reached the authorized amount of \$60 million with funding set at \$43 million in 2020.

Developments in 2008 and the Challenges of the Pandemic

In 2008, Congress passed the Fostering Connections to Success and Increasing Adoptions Act (PL 110-351). That law gave states the option to extend foster care up to the age of 21. Since this became an option, 26 states and the District of Columbia have extended care up to the age of 21 (Indiana extends it to age 20), but the remaining states (pre-COVID-19 pandemic) have not extended care. In the states that extend care to the age 21, young people have the option to stay in foster care if they choose. Some states allow young people the option to return to care if their first decision was to exit care at 18.

Congress recognized that assistance and services are needed for young adults beyond the age of 21. It has expanded Chafee support for transitioning young people to age 23 and Education Training Vouchers to age 26 for states with extended foster care programs through the Family First Prevention Services Act of 2018. In addition, several states that have developed models of care for older youth that improve permanency outcomes and provide youth with quality foster care placement and aftercare services.

In 2010 the Affordable Care Act (ACA) expanded Medicaid coverage for young people who have aged out or exited foster care. Mirroring the provision in the ACA that allows a parent to cover their adult child on their policy to the age of 26, the ACA mandates coverage of Medicaid

to the age of 26 if a young person ages out of foster care at 18. Due to a problem with the way this requirement was written, if a young person moves to a new state from the state they lived in while in foster care, the new state does not have to provide this Medicaid coverage. The 2018 Health Insurance for Former Foster Youth included an amendment to this provision so that all states will have to cover these youth starting on January 1, 2023.

The COVID-19 pandemic has focused a great deal of attention on the plight of youth in foster care. When schools and colleges closed and employers closed up, many of these youth were left in a difficult position with few options and limited support. The Children’s Bureau guided states in an effort to extend their foster care to 21 for youth that were faced with aging out of care but the pandemic has also shown the challenges for this population of youth.

Federal data through the *National Youth in Transition Database* tells us that when young people continue to age 21 in foster care compared to youth in foster care that “age out,” youth in care have better outcomes.¹⁰⁰

• Higher full and part-time employment	(67 percent v. 58 percent)
• Employment related skills	(37 percent v. 31 percent)
• Education aid	(31 percent v. 16 percent)
• Homelessness	(15 percent v 30 percent)
• Receiving public assistance	(N/A v. 31 percent)
• High school diploma or GED	(77 percent v. 68 percent)
• Attending school	(43 percent v. 23 percent)
• Referral for drug treatment	(6 percent v. 11 percent)
• Medicaid coverage	(90 percent v. 64 percent)
• Incarceration	(7 percent v. 23 percent)
• Giving birth or fathering a child	(14 percent v. 24 percent)

Society has changed since we first directed federal foster care funding to age 18 in 1980. In 1980, the average age for a first marriage was 24 years for a man and 22 years for a woman.¹⁰¹ By 2018, the average age for first marriage had risen to nearly 30 years for a man and just under 28 for a woman. At the same time, more young people are living in their parents’ homes for longer amounts of time. By 2015 a majority of young adults were living independently in just 6 states studied.¹⁰² Education also has changed.¹⁰³ By 2015, only 7.4 percent of students were completing two-year degrees within two years and only 10.1 percent were completing four-year degrees within four years of enrolling.

Traditional paths to adulthood no longer include finding a full-time job shortly after high school and retaining that job for years. Immediate marriage, enrollment, or being drafted into the military have all changed. So why do we expect a young person in foster care to turn 18 and on their birthday become automatically “independent”—despite the fact they do not have the same family, societal, and financial support and guidance their non-foster care peers have?

A Government Accountability Office (GAO)¹⁰⁴ report found that in the 26 states that do extend foster care, 38 percent of young people are in a family foster care arrangement, 34 percent are in a variation of independent living arrangements, and the remaining 28 percent are in a range of

institutional settings, including college dorms, group homes, maternity homes, Job Corps and other employment training settings, and voluntary substance abuse treatment facilities.

In addition to these changes, Congress has recognized that the advances in adolescent brain development are magnified when young people have concrete supports in times of need. This is clear in the passage of the “normalcy” provisions required through child welfare state plans. Research has shown that age zero to three is a critical period of development for infants and toddlers. Now we are learning that adolescent period is a vital time for growth and development. Young people are learning crucial cognitive development skills and navigating how to make decisions. This also is a crucial time for forming one’s self-identity. For youth in the foster care system, a sense of belonging is significant in supporting the needs and desires of each individual young person. The National Academies of Science, Engineering, and Medicine (the National Academies) report¹⁰⁵, *The Promise of Adolescence: Realizing Opportunity for All Youth*, explained that the “adolescent brain undergoes a remarkable transformation between puberty and the mid-20s.”

Older youth often have traumatic experiences prior to entering the foster care system and often are retraumatized prior to leaving the child welfare system, which impacts the adolescent brain. Since the period of adolescent development is crucial to opportunities for lifelong well-being, making decisions, and taking responsibilities, it is important that young people have guidance when exploring their own agency, are inclined to be engaged throughout their case-planning process, and should be given the opportunity to participate and have their voice heard.

Nationally, as many as 25% of youth leaving foster care experience homelessness during the year following emancipation.⁴⁹

It is a failure on our part when a young person exits foster care without a family. Extending care to 21 ***is not a goal but a commitment*** that if we have failed to find you a permanent family by the age of 18 you can continue in foster care at the young person’s choice. It is the least we can do while seeking policies that reduce and eliminate the number of youth that reach this stage.

Recommendations

Short-Term

The new Administration should:

- Sustain long-term support and services for this vulnerable population of young people through the pandemic to ensure their developmental needs are met and they have the skills and knowledge base to access the services and supports they will need during and after the transition to adulthood throughout the pandemic and related recession.

The child welfare system (including federal, state, and local governments and agencies and the communities they serve) should:

- Ensure all young people, regardless of their cultural, ethnic, racial identities, or gender identities receive services that address the full spectrum of their needs in a manner that reflects the cultural strengths of their families and communities.

- Ensure all young people have the consistent and quality of ongoing formal and informal supports and connections, including with relatives and siblings.
- Ensure all young people have access to mental health services and to the technology to use for the services available.
- Increase outreach to tribes and tribal consortia located within their states to determine resources the state may offer to help maintain the health and well-being of tribal youth.

Long-Term

Congress and the new Administration should:

- Require all 50 states to take the option of foster care to age 21 to all youth in care when they reach 18 while in foster care
- Increase funding significantly for the John H Chafee Foster Care Program for Successful Transition to Adulthood and the related Education and Training vouchers.
- Speed up the January 2023 timetable and immediately allow youth who age out of foster care to continue their Medicaid coverage to age 26 regardless of which state they reside in after they exit foster care.
- Restore the ban on discrimination in placement and recruitment decisions for youth in foster care and assure agencies respect and address the well-being of sexual and gender diverse youth in foster care.
- Reinstate the protections that were repealed in November 2019 that prohibited discrimination within programs under the jurisdiction of the Department of Health and Human Services.
- Create an incentive for states to cover in-state tuition for all Chafee eligible youth

Improving Juvenile Justice, Enhancing Systems Integration with Child Welfare, and Strengthening Delinquency Prevention

CWLA has consistently reported that child maltreatment researchers and practitioners, as well as those in the field of criminal justice, have been increasingly concerned about the long-term negative consequences of child abuse and neglect and the increased likelihood of abused and neglected youth to become involved in the juvenile justice system.¹⁰⁶ Although the evidence does not suggest any single factor accounts for the development of criminal behavior, experts increasingly recognize the importance of childhood victimization as a risk factor for subsequent delinquency and violence.

The fact that maltreatment is not inevitably associated with delinquency legitimizes the necessity for child welfare and juvenile justice systems to work in a coordinated and integrated manner. The overwhelming conclusion from this body of research is that to improve the well-being of our nation's most disadvantaged and traumatized children and youth, and to see sustained reductions in child maltreatment and delinquency, we must improve the coordination and integration of the child welfare and juvenile justice systems.

The Juvenile Justice and Delinquency Prevention Act

The Juvenile Justice and Delinquency Prevention Act (JJDP) is a federal initiative designed to help state and local governments and private nonprofit agencies in supporting and initiating programs that prevent and treat juvenile delinquency. Many public and private facilities nationwide provide custody and care for children who are wards of juvenile courts, juvenile corrections, or other public or private agencies. These facilities represent a spectrum of residential programs for accused or adjudicated delinquents and status offenders (youths detained for offenses that would not be crimes if they were adults, such as running away or truancy).

JJDP provides for a nationwide juvenile justice planning and advisory system spanning all states, territories, and the District of Columbia; federal funding for delinquency prevention and improvements in state and local juvenile justice programs and practices; and operation of a federal agency, the Office of Juvenile Justice and Delinquency Prevention, dedicated to training, technical assistance, model programs, and research and evaluation to support state and local efforts.

Established in 1974, and reauthorized most recently in 2018 with bipartisan support, JJDP is based on a broad consensus that children, youth, and families involved with the juvenile and criminal courts should be guarded by federal standards for care and custody, while also upholding community safety and preventing victimization. Reauthorization of the JJDP include cross-system protocols, policies, and procedures for juvenile justice and child welfare systems to collaborate and coordinate services for youth who are victims of abuse and neglect.

The connection between child maltreatment and later involvement with the juvenile justice system is well documented. As noted above, a growing body of research undeniably establishes the connection between all forms of child maltreatment—neglect, physical, and sexual abuse—and the risk of subsequent involvement in delinquency and the juvenile justice system.

Research confirms these maltreated youth frequently struggle in school and with mental health and substance abuse issues, all of which are often preludes to crime. The 2018 reauthorized JJDP Act recognized this critical issue and included provisions calling for policies and systems to incorporate relevant CPS records into juvenile justice records to establish and implement treatment plans for juvenile offenders. Unfortunately, real or perceived difficulties with data collection, information management, federal and state confidentiality statutes, agency mandates, and fiscal strictures often preclude these efforts.

The 2018 reauthorization added a new purpose under the Act to include: “to support a continuum of evidence-based or promising programs (including delinquency prevention, intervention, mental health, behavioral health and substance abuse treatment, family services, and services for

children exposed to violence) that are trauma informed, reflect the science of adolescent development, and are designed to meet the needs of at risk youth and youth who come into contact with the justice system.”¹⁰⁷

Some of the modifications in the 2018 legislation included encouraging states to: eliminate dangerous practices in confinement and to promote adoption of best practices and standards, including eliminating the use of restraints on pregnant girls; recognizing the impact of exposure to violence and trauma on adolescent behavior and development; promoting prevention and a comprehensive continuum of care through youth opportunity incentive grants; increasing family engagement in design and delivery of treatment and services; allowing for easier transfer of education credits for system-involved youth; and focusing on the particular needs of special youth population such as trafficked youth and Tribal youth.

The Family First Prevention Services Act of 2018 establishes investment in prevention and early intervention services offers opportunities for child welfare agencies to adopt policies and practices rooted in prevention that address child welfare pathways to delinquency. Family First unlocks new funding opportunities to provide preventative programs for at-risk families to keep children out of the foster care system. The reauthorization of the JJDP in 2018 addresses juvenile justice reforms that protect children in the youth justice system. Both laws focus on serving children in families and communities, decreasing out of home placements, investing in prevention programs, and addressing racial and ethnic disparities.

Barriers for youth involved in the child welfare and juvenile justice system include struggle with mental health problems, drug abuse, unemployment, homelessness, and recidivism. As states intend to implement Family First or delay implementation, this document provides recommendations for leveraging both prevention services and keeping youth in their homes and families.

Recommendations

Congress and the new Administration should:

- Provide further leadership and guidance to a nationwide implementation of reforms on behalf of this significant population of disadvantaged youth and families. CWLA has proposed language that would promote improved action.
- Strengthen coordination and improve protocols and procedures between these systems.
- Pass legislation to improve data collection on dual status youth and encourage better cooperation between state agencies overseeing juvenile justice and child welfare programs.

The new Administration should:

- Undertake an analysis of necessary services to prevent and treat these youth, then use that analysis to plan for providing such services.

- Modify AFCARS to establish process to identify the target population and collect data on the group

Pregnant and Parenting Youth in the Child Welfare System

For the child welfare system, pregnancy among youth in foster care can create additional challenges for the state system, youth, and their children, leaving youth in foster care even more vulnerable. With approximately 20,000 youth who “age out” each year, youth in foster care are more likely to become pregnant and parenting than their peers who have never been in care. In addition, African American youth disproportionately have a higher rate of pregnancy and parenthood than their peers.¹⁰⁸

There is limited data and reports on expectant and parenting youth in foster care; however, over the last decade, findings and studies have shown that outcomes for teen parents and their children involved with the child welfare system are disparate.

By age 19, a female in foster care is 2.5 times more likely to become pregnant compared to their peers not in foster care, and nearly 50 percent of males transitioning from foster care reported that they got their partner pregnant by age 21, compared to 19 percent of their peers not in foster care..¹⁰⁹ In addition, teen parents in foster care who have already had one child are at increased risk of having a subsequent birth before their 21st birthday.¹¹⁰

Adolescent childbearing, in combination with other preexisting factors, is linked to negative consequences for mother and child, and to significant costs to society. Teen childbearing costs taxpayers billions of dollars annually; \$2.8 billion of these costs fall on the child welfare system because children born to teen mothers are at increased risk of ending up in foster care and CPS.¹¹¹

In 2008, the passage of the Preventing Sex Trafficking and Strengthening Families Act (P.L. 113-183) requested that HHS collect annual data on the number of children in foster care who are pregnant and parenting using AFCARS data.

Another significant change to child welfare reform was the Family First Prevention Services Act that included changes for pregnant and parenting teens in foster care including allowing for this specific population to be considered for candidacy for prevention services. In addition, Family First allows for states to receive reimbursement for pregnant and parenting youth who are in congregate care setting to receive targeted services. These additional services are critical for preventing parenting and pregnant youth in foster care children from entering the system.

Recommendations

Congress and the new Administration should:

- Encourage more teen pregnancy prevention programs to serve youth in foster care and evaluate the effectiveness of interventions for that particular community.

- Invest in research and demonstration projects to develop or adapt existing evidence-based teen pregnancy prevention interventions for youth in foster care and those aging out of the system. Ensure that foster parents, other caretakers, independent-living staff, and other child welfare staff receive sufficient training to communicate with foster teens about relationships and pregnancy prevention and make sure they are linked with community resources.
- Issue guidance to states on how they can be meeting the needs of expectant and parenting youth in foster care and using the potential new source of funding in the Family First Act.

CHAPTER 6: The Health of Children and Families

Children in foster care are at higher risk for physical and mental health issues, stemming from the neglect or maltreatment that led to their separation from their parents, preexisting health conditions and long-term service needs, and/or from trauma associated with support systems, such as detention centers, residential settings' interventions or repeated removal from their community. Many children who come into contact with the child welfare system have been exposed to several traumatic experiences, including domestic violence, physical and emotional abuse, untreated parental mental health disorders, substance abuse, neglect, and the resulting impact that poverty can bring such as lack of nutrition or inadequate shelter.

Infants and toddlers, who are in extremely formative years, when exposed to such trauma, are at particular risk of developing hard-to-overcome emotional difficulties and developmental delays. Once placed in out-of-home care, separation from family members and continued instability often exacerbate the child's initial vulnerability. In the last ten years the foster care population has been getting younger. In 2009, children under the age of 5 (ages 0,1,2,3,4) represented 31 percent of all children in foster care. That percentage rose to 37 percent by 2019. At the same time the median age decreased from 9.7 years in 2009 compared to 7.7 years in 2019.¹¹²

Children enter out-of-home care for a variety of reasons. Some enter because of abuse or neglect. In other cases, families are compelled to place their children as a result of health, social, or economic stresses within the family, and sometimes children enter foster care because their families cannot access or pay for needed services for the children's behavioral or emotional issues.

Each child in foster care is entitled to quality services designed to ensure the child's safety and well-being. Public and private child welfare agencies assume responsibility for children's health and well-being when they are in out-of-home care.

Health care is vital for these children and young people, and for their families as well. Addressing health and behavioral health issues can be essential toward eventual reunification and permanence for children. Child welfare offers primary prevention through many means, including screening, assessments and access to health care, substance use treatment, and mental health services.

There is great concern that publicly supported health care coverage will be cut back. The COVID-19 pandemic has demonstrated the disproportionate impact of both preventing and caring for the virus and availability of health care coverage. Early data released in June 2020 by the Centers for Disease Control and Prevention (CDC) demonstrated access issue. CDC released data that examined the hospitalizations due to having the COVID-19 coronavirus and showed the disproportionate impact based on the race and ethnicity on patients with underlying health risks. Among 599,636 (45%) hospitalization cases with known information, 33% of persons were Hispanic or Latino of any race (Hispanic), 22% were non-Hispanic black (black), and 1.3% were non-Hispanic American Indian or Alaska Native (AI/AN).¹¹³

Health care access and health concerns add to the challenges communities are contending with along with poverty, access to housing, and lack of human services. Guaranteeing access to needed health and human services is vital to reducing the need for foster care and preventing child maltreatment.

The Affordable Care Act (ACA)

The Patient Protection and Affordable Care Act (ACA, P.L. 111-148) was passed by Congress and signed into law by President Barack Obama in 2010.

It has expanded health insurance coverage to 23 million Americans¹¹⁴ through two mechanisms: by creating health insurance exchanges that allow customers to purchase insurance plans meeting minimum requirements while also getting tax credits, and expanded the coverage of the Medicaid program while providing state governments major expansion supports.

The ACA requires specific protections and extension of benefits. Two of the most popular is the requirement allowing parents to purchase health insurance through their health care policies for adult children to age 26. Medicaid, under certain restrictions, has been extended to age 26 for a young person who has aged out of foster care. This protection does not extend to all youth formerly in foster care if they relocate to a different state. The second protection that is well known is the ACA provision that insurance companies cannot limit or deny coverage based on a “pre-existing” health condition.

Perhaps the most important health care benefit for child welfare purposes is the Essential Health Benefits or EHBs. EHBs mean that health care exchange plans must cover ten broad categories of services including: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness and chronic disease management; and pediatric services, including oral and vision care.

The expanded health care coverage through the ACA, including the expansion of Medicaid, has strengthened millions of families by improving their access to health care—especially those provisions that increased substance use disorder treatment and mental health services.

By 2017 the ACA had provided more than \$5.5 billion in substance use and mental health services, according to the research by Dr. Richard Frank and Dr. Sherry Glied of Harvard

Medical School and the New York University Wagner School of Public Service. It is critical that we maintain these services. (Frank, R.G., Glied, S.A., *The Hill*, January 11, 2017.)¹¹⁵

According to Dr. Frank and Dr. Glied, a full repeal of the ACA would result in a loss of coverage for 2.8 million people with a substance use disorder, including 220,000 people who have an opioid addiction. Additionally, it would eliminate mental health coverage to 1.2 million people with a serious mental health disorder.

Recommendations

Short-Term

The new Administration:

- Repeal President Trump’s executive orders and regulations that weaken the Essential Health Benefits (EHB) package
- Repeal President Trump’s executive orders that allow the sale of insurance policies that undercut the health exchanges.
- Expand the open enrollment period and increase the outreach effort to sign up new customers in the ACA

Long-Term

Congress and the new Administration should:

- Strengthen the ACA by enrolling all fifty states into the Medicaid expansion
- Create a public option allowing greater competition in the private health insurance market.

Title XXI, Children’s Health Insurance Program (CHIP)

Although Medicaid coverage is available to almost all children in foster care, the State Children’s Health Insurance Program (SCHIP) has successfully broadened health coverage for children and families who are low income, especially at-risk families and children transitioning out of foster care. The two programs have complimented each other in expanding overall access to health insurance coverage.

The CHIP program was reauthorized in 2018 for six years. The extension continued a 23-percentage point enhanced federal match rate for CHIP that was established by the Affordable Care Act but reduced the federal match rate to the regular CHIP rate over time. The 2018 law also extended the requirement for states to maintain coverage for children from 2019 through 2023. The extension also allows states to include CHIP children and those in look-alike programs in the same risk pool and specifies that CHIP look-alike programs qualify as minimum essential coverage. Look-alike programs are for children under 18 who are ineligible for

Medicaid and CHIP and purchase coverage through the state that provides benefits at least identical to CHIP funded through non-Federal funds including premiums.

As of June 2020, the combination of CHIP/Medicaid enrollment covered 36 million children.¹¹⁶ As of 2017, 19 states covered children at over 300 percent of poverty, 30 states covered children between 200 and 300 percent of poverty, and 2 states cover children at less than 200 percent of poverty. For this purpose, the poverty rate is based on 2016 figures for a family of three that was \$20,160.

CHIP enrollment has caused more parents to become enrolled in health care coverage. Following the implementation of the ACA Medicaid expansion in 2014, there were large increases in Medicaid and CHIP enrollment across states that followed steady growth in coverage of children over the past decade. The post-ACA expansions reflected enrollment among newly eligible adults in states that implemented the expansion as well as enrollment among previously eligible adults and children due to enhanced outreach and enrollment efforts and updated enrollment procedures tied to the ACA.

In the two years before the COVID-19 pandemic there was a decline in enrollment with total enrollment falling from 73.4 million in December 2017 to 71.1 million in December 2019. These declines stopped after February 2020 and the spread of the virus. The analysis of data by Kaiser found, “Recent data suggest that Medicaid enrollment is increasing amid the coronavirus pandemic. Actual adjusted data from February 2020 to preliminary data in June 2020 show that enrollment increased by 3.4 million or 4.8%.”¹¹⁷

Long-Term

Congress and the Administration:

- Reauthorize the Children’s Health Insurance program (CHIP)
- Extend the enhanced match to address any need in additional funds due to the COVID-19 pandemic and recession.

Medicaid

Child welfare agencies are responsible for meeting the health and mental health needs of all children in their custody. Virtually all children in foster care are eligible for and obtain health care services for both acute and long-term conditions through Medicaid. Considering the sheer volume and intensity of their health needs, Medicaid’s stepping in to provide children in foster care with physical and mental health services to help get them on the road to recovery is unquestionably vital.

Medicaid was created in 1965 along with Medicare. It serves the poor while Medicare provides coverage to those 65 and older. Medicaid provides health coverage to millions of low-income adults, children, pregnant women, elderly adults, and people with disabilities. It is administered by states and is matched by the federal government with at least half the costs paid for by the

federal government with some states getting as much as 75 percent of their costs covered by the federal government.

Medicaid is integral in the treatment of children in foster family homes, children with special needs in residential treatment, children who move from foster care to guardianship, and those with special needs adopted from foster care.

To receive federal matching funds, state Medicaid programs must provide beneficiaries with certain mandatory services. A mandatory service that is particularly important for children in foster care is Medicaid's comprehensive Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit. EPSDT requires states to periodically screen and ascertain if there are any potential physical, mental, developmental, dental, hearing, or vision related problems in children and provide any corresponding necessary treatment that will correct or ameliorate them or chronic conditions.

Despite EPSDT's broad benefits aimed at helping children who are the neediest, studies such as the GAO reported in 2001 have repeatedly shown that not all children are receiving the EPSDT services to which they are entitled by federal law.¹¹⁸ Access problems exist for several reasons, including a low provider participation in Medicaid often due to the low reimbursement rates, especially among mental health providers and dentists. Also, many parents are simply unaware of their children's right to EPSDT services.

With the passage of the ACA, Medicaid eligibility can be extended to nearly all low-income individuals with incomes at or below 138 percent of poverty (\$17,236 for an individual in 2019). While the Medicaid expansion was intended to be national, in June 2012, the U.S. Supreme Court issued a decision in *National Federation of Independent Business v. Sebelius*. The Court upheld the law and rejected the legal challenge seeking to wipe-out the ACA, but while they did uphold the law, the same decision said that Medicaid coverage cannot be cut-off from a state if they fail to expand coverage as provided in the ACA law. Medicaid expansion became "optional." Since 2012, the number of states not taking the Medicaid option has shrunk. As of the end of 2020, twelve states still do not extend Medicaid coverage.¹¹⁹

Before the pandemic, census data indicated that the ACA had reduced the uninsured number significantly from 50 million uninsured in 2010—before implementation- to 28.3 million in 2018. There were significant differences in coverage gains between states that have adopted the ACA's Medicaid expansion and those that held out. In expansion states, the uninsured rate had fallen from 18.4 percent in 2013 to 8.7 percent in 2018. In non-expansion states, the uninsured rate has dropped from 22.7 percent in 2013 to 17.5 percent this year.

Medicaid coverage is vital to families that adopt from foster care. A child receiving adoption assistance continues that Medicaid coverage. This can be a vital support to these adoptive families in addressing what can sometime be special health needs as well as future health challenges. Many families who adopt from foster care do not have a high income and so the extensive coverage Medicaid provides is critical, especially if a family adopts a sibling group of children or a child with high levels of medical needs. Medicaid is also critical to foster care with the federal government mandating coverage to at least those children covered by federal title IV-E foster care funds.

SSI-Adoption Assistance-Medicaid

Federal law treats categories of youth eligible for title IV-E differently and interferes with the ability of otherwise eligible youth to receive Medicaid benefits. Some states only provide Adoption Assistance to 18. Title IV-E eligibility carries with it mandatory eligibility for Medicaid so that when Adoption Assistance ends, the basis for that Medicaid ends. Some youth may continue to need Medicaid and seek an alternate eligibility category through which to receive it. Some may qualify for the Supplemental Security Income (SSI) program and seek to apply as an adult. In order to apply as an adult/under the adult criteria, a young person must be aged 18. This creates a problem. The application and determination process for SSI can be lengthy. This waiting period leaves a young person without the Medicaid they previously received through Adoption Assistance and awaiting coverage if found eligible for SSI. Youth receiving Adoption Assistance, are, by definition, youth found to have special needs. All youth need health care, youth eligible for Adoption Assistance need healthcare especially.

Historically, youth in foster care in these same circumstances- applying for SSI as an adult- were given the opportunity to apply for SSI at the age of 17.5 years in order to give the determination process a six month lead to prevent a lapse in coverage. This option should be made available to a young person whose Adoption Assistance will end at the age of 18. The Social Security Administration should equity allow youth whose Medicaid is ending via Adoption Assistance to apply for SSI at the age of 17.5 years.

Some states provide title IV-E Adoption Assistance to age 21. For youth adopted from these states, the application process for SSI does not create the same problem as it does for youth whose Adoption Assistance ends at 18. For youth, whose Adoption Assistance ends at 21, they can apply for SSI under the adult criteria at any point after age 18. They are continuously covered to age 21 by Medicaid via their Adoption Assistance eligibility. No exception is needed for this group of former Adoption Assistance recipients.

If Congress mandates Title IV-E Foster Care to the age of 21 for all states, Title IV-E Adoption Assistance would also be extended to age 21 and this problem would be addressed.

Medicaid Eligibility-Foster Care Maintenance Payments

As we've noted, federal law treats categories of youth eligible for title IV-E differently and interferes with the ability of otherwise eligible youth to receive Medicaid benefits. Youth eligible for Title IV-E Adoption Assistance are able to receive Medicaid, regardless of whether Adoption Assistance "is being provided." This means that a youth eligible for federal, adoption assistance can have a signed, Adoption Assistance Agreement in place to secure their assistance prior to adoption finalization, but not actively receive benefits under the Agreement either due to a request of the adoptive family or the fact that the child's eligibility is based on an "at risk" category of disability that has not manifested. Youth eligible for Title IV-E Foster Care, however, do not have this option.

Some states have waivers permitting placements in homes that are not licensed. Under federal law, these homes are unable to receive a Title IV-E Foster Care maintenance payment. This means that a youth who is otherwise eligible for Title IV-E Foster Care will be ineligible for a

payment in that placement. Under Medicaid law, a Foster Care maintenance payment must be received in order for a youth to receive Medicaid. Without a maintenance payment, the family loses financial support, and the child loses Medicaid. In interstate cases, a child may find themselves unable to receive Medicaid in the new state. The law was meant to serve as an incentive to ensuring safe homes but may disproportionately impact relative placements as these placements often seek waiver and are, by law, sought as a first choice in foster placements.

To overcome this outcome, some states will consider the child as a family of one and find them income-eligible for Medicaid. Others will direct the foster family to apply for TANF and independently seek Medicaid while others simply deny Medicaid and look to the family to support the child's healthcare needs. For any youth in the custody of state care, this is an unacceptable outcome.

Medicaid to Age 26

The ACA has expanded Medicaid coverage for young people who have aged out or exited foster care. Mirroring the provision in the ACA that allows a parent to cover their adult child on their policy to the age of 26, the ACA mandates coverage of Medicaid to the age of 26 if a young person ages out of foster care at 18. Due to a problem with the way this requirement was written, if a young person moves to a new state from the state they lived in while in foster care, the new state does not have to provide this Medicaid coverage. The 2018 Health Insurance for Former Foster Youth included an amendment to this provision so that all states will have to cover these youth starting on January 1, 2023.

Over the past two years the Administration has encouraged states, through the Medicaid waiver process, to enact work requirements on adults as a condition of be covered by Medicaid. To this point such requirements have been rejected or limited through courts actions. Work requirements have not been a part of Medicaid's history because it is a health insurance program. By at least one estimate up to 800,000 patients would lose health insurance coverage if these applied for work waivers are permitted.¹²⁰ This undercuts the mission of Medicaid to provide health care protections.

Medicaid has played a critical role in helping states address the opioid crisis. Several states were affected by the dramatic spread of opioid prescription drug abuse. As a result, foster care caseloads dramatically increased in these states. Nationally, foster care caseloads rose from a 13 year low of 397,000 in 2012 to a decade high of 440,000 in 2017.¹²¹

According to the National Center on Behavioral Health, many states with the highest opioid overdose death rates have used Medicaid to expand access to medication-assisted treatment. This includes 49.5 percent of medication-assisted treatment in Ohio, 44.7 percent in West Virginia, 44 percent in Kentucky, 34.2 percent in Alaska, and 29 percent in Pennsylvania. Imagine the impact on foster care caseloads, child maltreatment, and other areas of child welfare if Medicaid (and its expansion under the ACA) had been repealed in 2017 or 2018.

The Administration, through efforts to repeal the ACA in 2017 and 2018 as well as later budget proposals proposed a Medicaid block grant. The 2019 budget proposal included legislative proposals in Medicaid which produce net savings to the Federal budget of \$1,438.8 billion over

10 years. It would change Medicaid's fiscal structure by moving to a per capita cap or block grant structure. A per-capita cap allows a fixed allocation to each state based on a fixed formula by categories of people (i.e., elderly, disable, children, etc.).¹²²

IMD

When Congress passed the Family First Prevention Services Act, they created a new definition for child care institution (residential) services under foster care. The new Qualified Residential Treatment Program (QRTP) requirements, as created by the Act, appears to be in conflict with Medicaid's Institute for Mental Disease (IMD) exclusion. The IMD definition under Medicaid dates back to Medicaid's inception in 1965 with a goal of limiting the use of large mental health institutions.

Some states have been receiving interpretations that a QRTP could be classified as an IMD under Medicaid policy. In that case, no child or youth while they are residing in such a level of care would be covered by Medicaid services either at the QRTP or off-site. An IMD classification could cause states to shift toward more intensive placement facilities that would not be appropriate for many children and youth who may be more appropriately placed into a QRTP.

The use of Title IV-E funding, as well as Medicaid, are critical components in meeting the needs of children served in the foster care system. If QRTPs are maintained by a state but are not exempted from the IMD exclusion, then the entire cost of medical, dental, behavioral, and mental health care for each child placed into QRTPs would not be reimbursable through Medicaid. In the 2021 budget proposal the Administration suggests that addressing this requires a legislative fix. It would, in effect, exempt QRTPs from the IMD exclusion allowing children in foster care up to age 18 (or 21 if foster care is extended) to have Medicaid coverage in these QRTPs even if a QRTP qualifies as an IMD.

Recommendations

Short-Term

The new Administration:

- Reject any waiver proposals by states for a block grant
- Reject any state waiver proposal for work requirements through Medicaid

Congress and the new Administration should:

- Increase and extend the current Medicaid matching rate (FMAP) to no less than 12 percent to assist states in addressing the Covid-19 pandemic and recession
- Allow states to maintain this increase in FMAP based on future recession indicators (i.e. unemployment, etc.)
- Make sure that the FMAP increase for Medicaid also extends to state FMAP rates for Title IV-E foster care and adoption assistance.

Long-Term

Congress and the new Administration:

- Fix the IMD exclusion so that the new QRTPs are not classified by Medicaid as IMDs.
- Immediately allow youth who exit foster care due to age to continue their Medicaid coverage to age 26 regardless of which state they reside in after they exit foster care.
- Allow youth exiting Adoption Assistance to apply early for SSI as an adult so that their Medicaid coverage continues during the determination period.
- Mandate Medicaid coverage for all children and youth in foster care regardless of their in-state or out-of-state status and receipt of a foster care maintenance payment.
- Mandate or extend the Medicaid option to all fifty states under the ACA
- Ensure the availability of and accessibility to comprehensive preventive health care services guaranteed in federal law through EPSDT even if this requires adjustment to the reimbursement rates to better compensate and attract health care providers.
- Preserve the federal guarantee of Medicaid as an entitlement program for low-income children, youth, and families. Oppose efforts that attempt to restrict eligibility and reduce access or benefits.
- Identify actions to help increase the number of qualified providers accepting Medicaid and ensure they are properly trained to handle the unique physical and mental/behavioral health needs of children in foster care and that the rates for payment are adequate for the additional work that must take place when dealing with children and their families especially those involved with multiple systems.

Mental Health

Accessing mental health services is a significant component in child welfare issues. Thoroughly screening children involved with the child welfare and foster care systems' mental health needs, and providing appropriate treatment, is essential. Nationally and for the larger population, progress has been slow. Since 1963 when President John Kennedy signed the Community Mental Health Act, which altered the delivery of mental health services, to more recent years with the 2008 enactment of the Mental Health Parity and Addiction Equity Act and the expansion of that coverage through the ACA in 2010, it is clear that access to mental health services is vital but challenging.

CWLA recognizes this need and we have elevated the importance of this need with its formation and maintaining of the Child Mental Health Division and Advisory Board (MHAB).

The COVID-19 pandemic has highlighted these needs with anecdotal information of increasing mental health challenges by the general population, but there were already challenges before this current crisis. A CDC report issued in late 2019 found that among children and youth ages 10 to 24 years old, suicides climbed 56% between 2007 and 2017. Perhaps what is even worse is that the suicide rate for persons aged 10 to 14 nearly tripled from 2007 to 2017. The rate of homicide

deaths for the age group 10 to 24 decreased by 23% from 2007 to 2014 but then increased by 18% through 2017. This report was preceded by others on the general population.¹²³

There has been increasing attention to the relationship of children in foster care and the use of questionable increased use and type of psychotropic medications, partly because very few have been approved by the Food and Drug Administration for treating mental health disorders in children.¹²⁴ Studies have shown that children involved with the child welfare system are three to four times more likely than non-child welfare Medicaid recipients to receive psychotropic medications and at dosages beyond what is typically necessary. Although some extreme situations certainly warrant the use of psychotropic medications with children, their prescription and administration must be monitored closely. Congress has attempted to remedy this through state requirements on health planning and medical homes for children and youth in care.

The new Family First Prevention Services Act offers the potential to assist children and families involved with the child welfare service. Mental health services are among the three broad categories of service that can be covered under new Title IV-E entitlement funding if these mental health services can meet the evidence-based requirements of the new law. When fully implemented, it is hoped that any child or youth considered to be a “candidate” for foster care will be able to access services (services can extend to the family). As there are not sufficient numbers of evidence-based programs tailored for child welfare related populations additional models and services will need to be developed and they will have to coordinate with other parts of the U.S. mental health system.

In addition to Medicaid funding, several federal funding streams work to increase the mental well-being of children who are vulnerable. The Children’s Mental Health Services Program funds comprehensive, community-based systems of care for children with serious emotional disturbance (SED) in the nation’s child welfare, juvenile justice, and special education programs. The Community Mental Health Services Performance Partnership Block Grant is the principal federal program supporting community-based mental health services for children and adults. For children with an identified SED, these funds support services such as case management, emergency interventions, residential care, and 24-hour hotlines to stabilize children in crisis, as well as coordinate care for individuals with schizophrenia or manic depression who need extensive support. Despite these funding sources there continues to be a gap in the available services and families who either cannot access or pay for the needed services for their children’s behavioral or emotional issues are forced to give up custody to the state to do so and the children end up in the care of the child welfare agency.

As noted, the Affordable Care Act in its first years of implementation (through 2016) has provided more than \$5.5 billion in substance use and mental health services, according to recent research by Dr. Richard Frank and Dr. Sherry Glied of Harvard Medical School and the Wagner School of Public Service at NYU. It is critical that we keep these services in place.

Foster care numbers released by HHS indicated that in 2019, 437,4650 children were in foster care, an increase from the low of 397,000 in 2012.¹²⁵ AFCARS data indicates that drug abuse by the parent was the primary reason for the child’s removal in 34 percent of cases along with a child’s drug abuse in 2 percent of the cases. At the same time, a caretaker’s inability to cope was

a factor in a child's removal in 14 percent of cases and a child behavioral problem in 11 percent of the cases. The reduction or elimination of expanded behavioral health coverage would no doubt increase these numbers.

New mental health parity laws along with the ACA's Essential Health Benefits or EHBs requirements have provided important expansions of mental health services. These EHBs mean that exchange plans must cover ten broad categories of services: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; *mental health and substance use disorder services*, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness and chronic disease management; and pediatric services, including oral and vision care.

All of these systems must function together, especially since the Family First Act requires Medicaid to be the payor for mental health services if a state covers the specific services under the Medicaid program prior to the Title IV-E dollars being used. It will also be important to make sure that mental health services and models of treatment can be modified to adapt to a child welfare population.

Recommendations

Long-Term

Congress and the new administration should:

- Facilitate efforts to approve new models through the Family First Prevention Services Clearinghouse so that the number of approved mental health services can be approved more speedily.
- Allow adaptability for certain mental health services models so that they may be utilized in child welfare (for example, if a juvenile justice program offers effective services).
- Allow for the cultural adaptation of existing evidence based mental health services models to address the disparities and inequities for children and families of color especially those who are American Indian and Alaska Native.
- Increase funding for the Children's Mental Health Services Program, the Community Mental Health Services Performance Partnership Block Grant, Mental Health Programs of Regional and National Significance, and key programs that target the social and emotional development of infants and toddlers at heightened risk for mental health problems.
- Ensure availability and accessibility to comprehensive preventive health care services, including physical and mental health screenings and interventions, for children in foster care who are guaranteed these services under federal law through EPSDT for children younger than 21 receiving Medicaid. Particular attention should be paid to infants in foster care, ensuring they receive a comprehensive mental health evaluation and follow-up services.

- Increase funding for statewide family networks currently administered through SAMSHA discretionary funds.
- Fund training and technical assistance specific to statewide family networks
- Fund research on culturally responsive evidence based mental health prevention and treatment services for children and families of color.

Substance Use

Children’s exposure to parental alcohol and other drug (AOD) use—whether through prenatal exposure or environmental observation—undoubtedly puts them at risk. Substance abuse is estimated to be a factor in one- to two-thirds of cases of children with substantiated reports of abuse and neglect, and in two-thirds of cases of children in foster care.¹²⁶ Children from families with substance abuse problems tend to come to the attention of child welfare agencies at a younger age than other children, are more likely than other children to be placed in out-of-home care, and are likely to remain there longer.¹²⁷ In addition, attention is required regarding substance use exposure for the infants since that impact may not surface until later in a young child’s or adolescent’s life to fully understand the effect in later developmental stages.

As noted earlier in this document, foster care numbers released by HHS indicated that in 2019, 437,4650 children were in foster care. The data indicates that drug abuse by the parent was the primary reason for the child’s removal in 34 percent of cases along with a child’s drug abuse in 2 percent of the cases.¹²⁸

The Assistant Secretary for Planning and Evaluation (ASPE) released a 2018 study that examined the child welfare caseload and the impact of substance use. *The Relationship Between Substance Use Indicators and Child Welfare Caseloads*¹²⁹ report looked at the data at the county level. They found that hospitalizations are related to caseloads. Hospitalizations due to opioids resulted in a 2.2 percent increase in foster care entry rates compared to a 2.8 percent increase in foster care rates when the hospitalization was due to alcohol abuse. But many abuse cases may involve multiple drug problems and cases are overall more complex.

These factors are not new. In 1992, CWLA released a survey linking the drug epidemic to the 50 percent increase in foster care over the previous five years. The survey of several states and agencies found that of 305,716 children served in the previous year, 36.8 percent were from families in which there was a caregiver with an alcohol- or drug-abuse issue or were themselves alcohol or drug abusers. Private agencies and CPS workers indicated an even higher percentage.

If not treated properly, parental substance abuse is troublesome; in addition to being a root cause of child abuse and neglect, often it is cyclical and intergenerational in nature. Studies have shown that children who grow up in homes plagued by alcohol and other drug use and abuse very often choose risky behavior and develop their own alcohol and other drug problems.

To ensure safety and permanence for these children, and appropriate alcohol and drug treatment for their families, increased treatment, and other services must be directed to their special needs. This will require increased resources and new partnerships between child welfare and state substance abuse agencies.

It is worth repeating that the new Family First Prevention Services Act offers the potential to assist children and families involved with the child welfare service. Substance abuse (like mental health services) is among the three broad categories of service that can be covered under new Title IV-E entitlement funding if these prevention and treatment services can meet the evidence-based requirements of the new law. When fully implemented, it is hoped that any child or youth considered to be a “candidate” for foster care will be able to access services (services can extend to the family). But these models and services will need to be developed and they will have to coordinate with other parts of the U.S. mental health system.

Substance use treatment agencies, other service providers, courts, housing authorities, community leaders, and family members need to coordinate. In past congresses, legislation has been introduced to provide grants to state child welfare and alcohol and drug agencies to address the effects of alcohol and drug abuse on children and families who come to the attention of the child welfare system.

Substance abuse treatment services that are specifically tailored to meet the needs of women and parents are in short supply. Parents in the child welfare system with alcohol and other drug (AOD) problems have multiple and especially complex problems. The mothers involved often face mental illness, domestic violence, health problems like HIV/AIDS, and have a history of abuse or neglect as a child—all of which pose special challenges for AOD treatment and recovery. To ensure permanency decisions can be made for children whose families have AOD problems, special steps must be taken to begin services and treatment for the family immediately upon a child’s entry into foster care. The Family First Prevention Services Act also allows states to use foster care maintenance payment for a child placed with his or her parent within a residential substance abuse treatment facility. The challenge is that these facilities may not be widely available and with the child placement of a child into the facility now meeting the definition of an IMD, a recent waiver was granted to allow an exception but only when the parent has an opioid use disorder diagnosis. As most individuals who abuse substances usually use more than one and this has significantly limited the availability of this critical treatment option of families involved with child welfare.

In 2006, Congress created nationally competitive grants with the goal of funding treatment programs. These Regional Partnership Grants (RPGs) were enacted as part of the Deficit Reduction Act of 2006. These grants, allocated through the Title IV-B PSSF program, were limited to \$40 million in the first year, decreasing to \$20 million in the fifth.

These RPGs were a good but very small start and will hopefully result in evidence-based programs that will qualify for coverage under the Family First Act. They also represented a prime example of the disproportionate approach to child welfare. The original 2006 grants started off targeting the use of methamphetamines. These areas were mainly rural and white.

In more recent years Congress has stepped up in providing significant amounts of treatment dollars to address the opioid epidemic. This greater emphasis on treatment over punishment is a long overdue response to this nation’s drug problems and epidemics. Unfortunately, this too took an epidemic that hit predominantly white rural and suburban areas. We need to expand this

emphasis on treatment first of all because it is an illness, secondly because it is a vital strategy to reducing child maltreatment and foster care placements.

Recommendations

Short-Term

The Administration should:

- Call together in a joint conference (in-person if possible) all the state child welfare and substance use directors in an effort to begin state level dialogues to coordinate and facilitate the provision of substance use prevention and treatment services between these two systems. (This conference could also involve the Medicaid directors.)

Congress and the new Administration should:

- Congress should re-visit legislation first proposed by Senator Jay Rockefeller (D-WV) and Senator Olympia Snowe (R-ME) in 2000 that would have provided coordination grants to state child welfare and substance use directors to coordinate treatment and services. Such legislation could be much lower cost since Congress has now created the Family First Prevention Services funding source.
- Facilitate efforts to approve new models through the Family First Prevention Services Clearinghouse so that the number of approved substance use treatment services can be approved more speedily.
- Broaden the use of the opioid treatment funding that Congress has approved since 2016. In many instances, an individual who has a substance use addiction will use more than one substance and these limitations on treatment funds may limit the availability of needed treatment.
- Allow for the cultural adaptation of existing evidence-based substance use prevention and treatment services models to address the disparities and inequities for children and families of color especially those who are American Indian and Alaska Native.
- Funding of research on culturally responsive evidence based substance use prevention and treatment services for children and families of color.

CHAPTER 7: The Fundamental Building Blocks of a Successful System for Children and Families: *Workforce*

With the 2020 debate over racial equity, one area of focus is how racism has affected child welfare services and decisions over the past decades. Much of the focus on access to prevention services, child protection practices, and interventions that may result in the removal of a child from a family has been on the role of the staff and workforce that are tasked with providing these services and making these decisions. One thing should be clear, if staff are not trained, retained, and supported, the resulting turnover makes change impossible or at least unstable.

When we issued a transition paper in 2009,¹³⁰ we referenced the results of an informal CWLA survey of state child welfare officials conducted in August 2008 that found general consensus on the greatest challenges for the child welfare workforce. States indicated that they were faced with the challenge of keeping good workers on the job and fighting to reduce turnover. Closely related to this, and in fact contributing to turnover, is trying to maintain a large enough supply of competent supervisors who can provide critical support to frontline and direct service staff. These veteran workers are key to ensuring high practice standards are implemented and followed per agency policy.

But in a more recent publication examining the evidence base, current trends and future directions for caseloads and workloads in child welfare, it was found that “the time workers had available to serve the families is substantially less than the amount of work to be done”.¹³¹ In the 29 workload studies examined NONE of the jurisdictional studies indicated a need for less workers but rather a significant need for additional workers that ranges from a 34 to 934 depending on the size of the jurisdiction and the service area. While workers only had 63-76% of their time available to spend with families the majority of that time went to case related work which took away from the available time with the family.¹³²

The workforce does make a difference. According to the New York City-based Fostering Change for Children, up to 40 percent of child welfare caseworkers leave their jobs every year.¹³³ More importantly, they tell us: “Children with one caseworker achieve permanency in 74.5 percent of cases. But the more caseworkers involved in a child’s life, the less chance that a child has to achieve permanency, ranging from 17.5% for children with two caseworkers, to the low rate of 0.1% for children who had six or seven caseworkers during their time in care.”¹³⁴

That alone should make the child welfare advocacy community sit up and pay attention to the need to strengthen the child welfare workforce. By strengthening the workforce and ensuring they have manageable workloads this will achieve a reduction in child abuse, reduce the number of children going into foster care, and increase adoptions for children of all ages.

An effort to address implicit and explicit bias is contingent on having a workforce that does not constantly churn and turnover because that kind of a workplace atmosphere guarantees it will be more difficult to find the dedicated men and women willing to work under unacceptable conditions.

The Quality Improvement Center for Workforce Development (QIC)¹³⁵ tells us that child welfare workers stay on the job for an average of two years. If you have to re-teach or re-train your workers on implicit bias every two years can progress be achieved? When that many staff are leaving what does that do to the rest of the existing staff who must carry the additional cases left by the departing worker. What is the cumulative toll to the existing workforce that must constantly be picking up for workers who depart?

The QIC tells us: Half of supervisors were in that position for less than 2.5 years; an average state has an annual turnover rate of 14% - 22% for caseworkers and about 20% for supervisors; and seventeen states have annual worker turnover that is greater than 25% of their workforce.

The research also tells us that some child welfare workers have an annual caseload of about 19 cases or less, while others had a caseload of 97 cases per year with the median caseworker handling 55 cases in a year and 10% of the caseworkers identified in the NCANDS files had a caseload of more than 130 cases per year.¹³⁶ Given large numbers of cases are open more than a year this means that many workers could at any one time be carrying numbers of cases that far exceed the CWLA standards of either no more than 12 for CPS cases and no more than 17 cases for foster care. While many states have utilized the CWLA caseload standards in their legislation they struggle to keep their caseload sizes at these maximum numbers as they are usually considerably higher.

Caseload size is closely related to the workload. Child welfare work is labor intensive. Workers must engage families through face-to-face contact, assess children's safety and well-being through physical visits, monitor progress, coordinate with multiple systems that the families are involved with (such as housing, adult substance abuse and mental health treatment systems, child care, domestic violence, medical, probation, and legal), see that children and their families receive essential services and supports across multiple systems, prepare documentation for and go to court, help with problems that develop, and fulfill data collection and reporting requirements.

A research paper by the American Federation of State, County and Municipal Employees (AFSCME) Department of Research and Collective Bargaining Services reinforce just how workforce issue change the lives of children and families within the child welfare system:¹³⁷

- A study that compared high-turnover and low-turnover counties in New York State found that low turnover counties have lower median caseloads, which allows workers to spend more time directly with youth and families.
- In a study comparing outcomes of 12 California county child welfare agencies that were grouped into three segments based on their average turnover rate, low-turnover counties had significantly lower maltreatment recurrence rates and higher compliance with recognized practice standards. High-turnover counties had the highest rates of re-abuse and had twice as many recurrences of abuse and neglect as the low-turnover counties.
- Researchers and child welfare stakeholders have consistently found that high turnover has devastating consequences for youth and families in the child welfare system, including:
 - lower permanency rates
 - greater instability (more changes in placement)
 - longer stays in foster care
 - decreased chances of timely reunification
 - loss of trust between youth and caseworkers, and
 - impairment of agency functioning, such as delaying the timeliness of investigations, limiting the frequency of worker visits with children, and failure to meet a variety of federal performance standards.

The HOMEBUILDERS model of family preservation has recently been recognized by the Family First Prevention Service Clearinghouse as an evidence-based model. Over the decades it

has been built on a rigorous model that includes intensive intervention with therapists typically serving two families at a time and provide 80 to 100 hours of service, with an average of 45 hours of face-to-face contact with the family.¹³⁸ The workforce is a key to success.

Recognizing the importance of the workforce in evidence-based practices funded through the Family First Services program, the legislation requires a description of steps the state is taking to support and enhance a competent, skilled, and professional child welfare workforce to deliver trauma-informed and evidence-based services. This includes ensuring staff is qualified to provide services or programs that are consistent with the practice model; how the state will provide training and support for caseworkers; and how caseload size and type for prevention caseworkers will be determined, managed, and overseen.

Research

A Nebraska project funded under the QIC identified numerous contributors to turnover and one factor is secondary stress. More than half of the state workforce participated in a survey and more than half of those surveyed reported elevated levels of secondary traumatic stress. They also said there was a lack of organizational and professional supports available to help them manage that stress.¹³⁹

In Oklahoma,¹⁴⁰ a 2012 Consent Decree established a workload standard for all caseload-carrying child welfare specialists. According to the QIC, Oklahoma has too many staff with a workload that exceeds the standards for their program area. In Louisiana,¹⁴¹ an assessment revealed high caseloads and the large number of administrative task responsibilities were barriers to caseworkers 'ability to support families, engage clients, determine root causes of abuse and neglect, and implement appropriate services in a timely manner'. Those challenges led to low employee morale, high turnover, and poor outcomes for families and children.

The U.S. General Accounting Office (GAO) documented this crisis in the child welfare workforce more than 10 years ago, finding the child welfare system is seriously understaffed, undertrained, and undervalued. GAO found these workforce problems limit states' ability to meet the goals established in the CFSRs.¹⁴²

Racial Equity –Requires A Strong, Well-Trained, Retained, and Supported Workforce

If a workforce is stabilized with reduced turnover and manageable workloads, it offers a greater opportunity to address issues of workforce bias as opposed to the training and retraining as new workers are constantly being hired. According to the National Child Welfare Workforce Institute,¹⁴³ the steps that leadership should take to address hidden biases in the workplace include:

- Recognize that individuals have conscious and unconscious biases, demonstrate a commitment to diversity, and practice cultural humility and awareness.
- Openly and explicitly address the organization's intention to optimize cultural diversity and avoid the hazards of institutional biases and racism at all levels. Creating teams to identify structural and operational bias within the organization can assist in recognizing and mitigating the impact of biases.

- Create a senior management position for a diversity officer. The diversity officer should set up educational programs and evaluation protocols that establish standards of cultural awareness.
- Create and articulate distinct, functional, and inclusive strategies promoting equity and cultural diversity.
- Be mindful of succession planning at all times. Organizational practices should include mentoring and training professionals from communities of color, recruiting graduating students and young professionals from diverse cultural backgrounds, and advertising in media that are accessible to individuals from underrepresented racial, ethnic, and cultural groups.

Training alone is not the solution to addressing bias since much of the disproportionality we have been discussing in 2020 is also affected by other non-workforce factors such as the availability and access to culturally appropriate and responsive human services and family supports. A well-trained workforce that is stable is a foundation for improvement.

Strategies

One model approach to workforce development is Fostering Change for Children's Corp in New York City. Children's Corps uses a 3-pronged model: Strategic Recruitment and Selection; Pre-service Training; and On-going Support and Professional Development

Participants are placed at one of sixteen partner child welfare agencies throughout New York City and Westchester county in caseworker and other frontline positions in foster care and preventive programs. Corps members commit to serving for two-years and agencies provide full salaries and benefits. The Children's Corps average retention rate after one year is 81%, compared to the New York City average retention rate of 60-65%. Many continue as part of a Children's Corps alum who have completed the two-year commitment at their child welfare agencies. A majority of alum continue to work at the child welfare agencies they started, often with promotions, while others have pursued a higher education in a field related to child welfare. Recruitment is an important first step in building a child welfare workforce. In 2008, Congress reauthorized the Higher Education Act. As part of that reauthorization, Congress created a loan forgiveness program that covers child welfare workers working for public or private agencies. This new program could provide up to \$2,000 of loan forgiveness for each of the first five years a social worker remains at an agency. To implement this new program, Congress had to provide an annual appropriation but 12 years later that has never happened.

In that same period, Congress instituted a loan forgiveness program that did not require an annual appropriation. Under the College Cost Reduction and Access Act of 2007 (P.L. 110-84), people who work ten years in "public service" and pay for their federal student loans (120 payments over ten years) can have the remaining loan forgiven.

Under the law, covered public service jobs include full-time employment (at least 30 hours a week) in several professions at any level of government, including the military, public safety, law enforcement, the Peace Corps or AmeriCorps; public education, including early childhood education; social work in a public child or family services agency (*this includes child welfare*);

public interest legal services, public or school-based libraries; public service in child care, service for individuals with disabilities, or the elderly; and teaching at a tribal college or in a high-needs area as determined by the Department of Education.

By 2018, more than 41,000 public servants have applied for loan forgiveness, but only 206 people have received loan forgiveness by the U.S. Department of Education. Congressman Danny Davis (D-IL) worked to provide one-time funding to address the problems with the loan and forgiveness requirements. The bill allowed up to \$500 million in loan forgiveness for the Temporary Expanded Public Service Loan Forgiveness (PSLF) program. The funds are to provide forgiveness for public servants who were denied solely because they were in the wrong federal student loan payment plan.

With the Fostering Connection to Success Act of 2008, Congress expanded Title IV-E training funds to private agencies and to court and child welfare-related employees, such as CASAs and guardian ad litem. More recently, the Children's Bureau has given guidance and encouragement for states to use administrative funding to provide legal counsel to families, but these funds are a challenge. Much of Title IV-E funding is tied to what percentage of a state's workforce serve a child welfare population that is covered by Title IV-E funding. So if only half the children in foster care are covered by federal funds, then a state can get a match on the training of only half the training funds.

Quality supervision is another key strategy for successful retention of child welfare workers. The supervisors play a pivotal role in enhancing the retention and performance of the staff. Using coaching techniques with case workers supervisors are able to aid workers in building and strengthen their knowledge and skills, increasing their confidence, improving implementation of effective practices, and make progress toward the case specific goals. Additional techniques of quality supervision include reflective supervision which help workers understand themselves in the context of their work, their own biases, and to move beyond their stuck points. But to accomplish this type of quality supervision requires funding for the training and support of the supervisors.

The COVID-19 pandemic has reminded us of the importance of this workforce—and the challenges they face. In residential care settings, the facilities must have a back-up staff strategy if staff become sick or member of their family test positive. If children or youth become sick, the facility may have to isolate that child(ren) and contact by staff and others. This can be a challenge with limited and low-paid staff and limited physical space.

In some instances (child protection) workers may be required to make in-home visits. In other instances, they may have to transport children, and in other cases they may have to facilitate face to face meetings with a parent or child. Other challenges may include identifying available non-emergency medical transport options for children with known or suspected contraction of coronavirus ; employees having the appropriate access and use of personal protection equipment (PPE); after transporting the passenger, employees need to clean and disinfect the vehicles; after work shift, employees should launder their work uniform/clothes worn when transporting sick child.

With the passage of the ACA, Congress recognized the need to increase the number of health professionals including doctors, nurses, nurse aides, specialists, dentists, and other parts of the health system. If more people can receive and afford health care, then it is likely more health professionals would be needed especially in parts of the country where a shortage already existed. The ACA expanded existing education training and loan programs and created new programs designed to increase the supply of various health care professionals. Generally, these federally funded health care workforce development programs revolve around broad categories of training physicians, training non-physician professionals, addressing geographic shortages of health care workers, and promoting workforce diversity.¹⁴⁴

The child welfare field is nowhere near the size of the healthcare field but such training and education initiatives can serve as a model at a smaller scale. Like many other critical human services (child care teachers, Head Start teachers, long term care workers, mental health workers and several other social work categories), child welfare workers face the same challenges: providing vital work for some of the most vulnerable populations and dependents. They also work under the same lacking conditions: low pay for difficult work, high turnover with limited staff support and large caseloads.

This suggests the need for a national human services workforce strategy. Much of this work cannot be replaced by artificial intelligence or foreign job relocations. One thing is certain, the work will not go away as the needs of these children and families will not either.

Recommendations

Short-term

The new Administration should:

- Provide technical assistance to states on how to draw down and leverage Title IV-E training funds to expand training of the child welfare workforce.
- Provide technical assistance to states on how to draw down and leverage Title IV-E training funds particularly on strategies that allow states to pass through training funds to private agencies contracted by the child welfare agency. This option, created in the 2008 Fostering Connections to Success Act, has not been leveraged.

Long-Term

Congress and the new Administration should:

- Create a new human services workforce strategy that can promote some of the most important human services jobs, including the child welfare workforce. Provide loans and job promotion similar to the health care workforce strategy.

- De-link the Title IV-E foster care and kinship care subsidies from the 1996 AFDC eligibility standards to expand much needed administrative and training funds for child welfare workers.
- If a total de-link of all Title IV-E funds is not possible, de-link at least the administrative and training funds from the 1996 AFDC eligibility standards. This will expand state's access to funds that can support the entire child welfare workforce not just those with Title IV-E eligible caseloads.
- Fully fund the loan forgiveness program enacted as part of the 2008 Higher Education Reauthorization Act.
- Fix the ten-year loan forgiveness program so that public servants, including child welfare professionals, can access these funds.
- Significantly increase the \$7 million in Title IV-B part 1, training funds, to allow all 50 states to build or strengthen university and college partnerships to recruit, train, and strengthen the child welfare workforce.
- Supplement the current \$20 million allocated under PSSF, Title IV-B, part 2, with a nationally competitive grant program that can fund state initiatives, innovations and data collection on the workforce by states that want to increase and strengthen the child welfare workforce.
- Create a separate direct grant program that can fund local competitive applicants that want to develop, (develop) data on, and expand their workforce development strategies.

Chapter 8: Immigration

When some people begin to discuss child welfare in the United States they frequently point to the “orphan” trains of the 19th and early 20th centuries as the horror that mankind can do—especially when the retrospective is 150 years later.¹⁴⁵ As one historian wrote: “By modern standards, the process of placing children with strangers during what amounted to a mass adoption event would be considered cruel and dangerous. Vetting was lax, if potential parents were vetted at all, and some children were placed with people who treated them as servants.”

A century from now, what horror will people look back on in the early part of the 21st Century? It very well could be that the United States federal government had a policy that they would intentionally take children away from their parents as an immigration deterrent policy. A policy that applied even when the families were leaving their homelands and seeking refuge from violence that was life-threatening and child-threatening. At least in the 19th century when they moved homeless children, they had little understanding of brain science or early childhood development. In 2020, we do not have any such excuses.

This child separation policy from 2017 and 2018 was intentional¹⁴⁶ and by late 2020, at least 545 children have not been reunified with their parents because the government failed to track or find them.¹⁴⁷

Families are central to child well-being. Family ties, especially between parent and child, are extremely important. *CWLA Standards of Excellence for Services to Strengthen and Preserve Families and Children* provide a vision for what is best for children and their families.¹⁴⁸

“Families are central to child safety and well-being. Children develop the ability to lead productive, satisfying, and independent lives in the context of their families. Family ties, especially those between parent and child, are extremely important in the development of a child’s identity. Through interaction with parents and other significant family members, children learn and come to subscribe to their most cherished personal and cultural values and beliefs, learn right from wrong, and gain competence and confidence. Family relationships must be nurtured and maintained to meet the needs of children for continuity and stability, which support healthy development.”

According to the American Immigration Council, children experience toxic stress when they are suddenly separated from their parents. Although the number of children who become involved in the child welfare system as a result of immigration enforcement is not clear, studies indicate the devastating impacts of enforcement activities on children. Immigration-related parental arrests (at home or worksites) resulted in the majority of children experiencing at least four adverse behavioral changes in the six months following a raid or arrest. Compared to the previous six months, children cried or were afraid more often; changed their eating or sleeping habits; and/or were more anxious, withdrawn, clingy, angry, or aggressive.¹⁴⁹ Being separated from their family members and their communities, cultural familiarities, and schools, along with other connections, can cause children to struggle with their identity and face an undue sense of isolation, adding further stress to an already traumatic situation.

CWLA does not lay claim to being experts on immigration policy but we do recognize the importance of valuing families, building communities and the importance of diversity to both. Congress must enact fair immigration reform, suspend mass deportations, and create laws that prohibit policies that deter immigration by separating children from their parents. The federal government needs to re-establish our long tradition of having policies that recognizes and supports families seeking refuge from violence and political persecution for themselves and their children.

More than 17 million U.S. citizen children have at least one foreign-born parent, including parents who are naturalized citizens, lawfully present immigrants, and unauthorized immigrants. More than 5.9 million U.S.-born citizen children have at least one undocumented parent, and 90% of these children are themselves U.S. citizens.¹⁵⁰ The numbers of unaccompanied children arriving to the United States have also spiked in recent years, peaking in 2014 and rising again in 2016, with nearly 60,000 arrivals that year and 100,000 more since then (U.S. Customs and Border Protection, 2016; 2018).

Immigration enforcement officials should employ humane policies and procedures when dealing with arrest, detention, and processing of anyone involved in workplace immigration enforcement operations, and especially anyone with children. Enforcement must be done in a way that is less threatening and protects the children involved.

These policies need to guarantee the rights of applicants and avoid using U.S. child welfare courts since child welfare policy and practice is not based on the same circumstances and consideration that immigrant families face.

The Deferred Action for Childhood Arrivals (DACA) program allows many youth who are immigrants to fulfill their dreams of attending and completing college, to work legally, pay taxes, provide for their families, and find ways to contribute to the country they call home without fear of deportation. This significant increase in enrollment of DACA recipients in school and participation in the workforce is evidence of the positive impact of policies that increase opportunities and access to critical resources.

The original DREAM Act must be passed, and the current Deferred Action for Childhood Arrival (DACA) program must be restored to its original provisions and protections as outlined by President Obama's Executive Order in June 2012.

In past Congresses, there have been several bipartisan "Dreamers Acts," including the DREAM (Development, Relief, and Education for Alien Minors) Act of 2017. Past legislation grants DACA (Deferred Action for Childhood Arrivals) beneficiaries' permanent resident status on a conditional basis. Conditions include passing a background check and medical exam and entering the United States before a certain date and age. Dreamers must also meet educational requirements, including having been admitted to a college, university, or institution of higher ; having earned a high school diploma or general education development (GED) certificate; or currently being enrolled in a secondary education program to obtain a high school diploma or GED certificate. Dreamers cannot have been convicted of criminal offenses.

Since 2012, some 825,000 undocumented young adults who came to the United States as children have received permission to remain in the country and work lawfully under the Deferred Action for Childhood Arrivals (DACA) initiative.¹⁵¹

During the COVID-19 pandemic, 29,000 DACA recipients have been on the frontlines as health care workers.¹⁵² The Administration has created a new rule that makes it harder for immigrants to obtain green cards and access government aid by expanding the definition of who would be considered a "public charge" to ensure immigrants would not depend on the government for their income. The Administration policy denies entrance or permission to work to immigrants if they have made use of benefits programs such as Medicaid, SNAP, or public housing, and would exclude immigrants with low incomes.

The combination of all of these collective policies, rules and regulations, enforcement actions and threats from the White House have caused many immigrant families to stop making use of benefits despite their eligibility for them because of fear they will lose legal status. This becomes even more dangerous during the COVID-19 pandemic.

We need a more humane immigration policy both because it is the way we have built this country and because future labor force needs will require it. So will our basic decency.

Recommendations

Short-Term

The new Administration should:

- Immediately suspend any child separation policies still in effect.
- Restore DACA as created in 2012
- Repeal the new rule on what is a “public charge”
- Allow Court Improvement Program funds to be used to train judges and lawyers to assist children with immigration options.
- Follow the Flores Agreement regarding child and family separation and the provision of essential services including basic education needs for children.

Long-Term

The Administration and Congress should:

- Provide a path to citizenship for approximately 11 million undocumented immigrants.
- Provide guidance and technical assistance to all states and child welfare agencies on proper handling of immigration issues.
- Ensure immigration enforcement officials give sufficient notice to state child and human service agencies of impending raids so the agencies can arrange for representatives who speak the detainees’ first language, and for any other services that may be necessary.
- Ensure child welfare systems help immigrant children obtain legal permanent residency under the Special Immigrant Juvenile Status provisions and other immigration options of existing immigration law.
- Ensure immigration authorities and child welfare agencies consider the children’s best interest—safety, permanency, and well-being—in all decisions concerning immigrant children.
- Assist states and local agencies in screening all children in the child welfare system as to their eligibility under immigration options.
- As part of any immigration reform, include ways to collect data about immigrants in the child welfare system. Policymakers and community agencies need accurate data about the

immigration status of children in their communities. This information is necessary to be responsive to immediate and emerging needs.

- Prohibit immigration status alone from being a factor in placement decisions and permits certain forms of foreign identification for purposes of a background check. These provisions can help in placing these children in relative-kinship care.

Chapter 9: Poverty

The U.S. Census Bureau reported that 34 million people in the U.S. lived in poverty in 2019, with 10.5 million children living in poverty, the official poverty line for a family of four with two children is \$26,000 a year. Research has shown that poverty is associated with negative outcomes for the entire family. And children of color continue to experience poverty at a rate nearly three times that of white children.

When we focus on important child welfare policy goals including preventing child abuse and neglect or when we set goals to prevent family separation and reducing foster care a critical first step is including a strategy on reducing poverty.

As we had highlighted in our 2009 transition paper, research indicates poverty as a contributing factor to disproportionality. A 2007 GAO report on African American children in foster care found that 23% of African Americans lived below poverty levels, compared with only 6% of whites.¹⁵³

More than a decade later, in 2019 the National Academy of Sciences in their report, *A Roadmap to Reducing Child Poverty (2019)*, pointed out the potential impact poverty can have on the child and child development. “Some children are resilient to a number of the adverse impacts of poverty, but many studies show significant associations between poverty and child maltreatment, adverse childhood experiences, increased material hardship, worse physical health, low birth weight, structural changes in brain development, mental health problems, decreased educational attainment, and increased risky behaviors, delinquency, and criminal behavior in adolescence and adulthood. As for the timing and severity of poverty, the literature documents that poverty in early childhood, prolonged poverty, and deep poverty are all associated with worse child and adult outcomes.”¹⁵⁴

During the past few months of discussion on the level of child abuse reporting, many people have confused or combined the issue of child “maltreatment” with poverty. They have pointed out, correctly, that a majority of substantiated child maltreatment cases are categorized as neglect. But they then conclude that substantiation of child abuse is based on poverty. It is much more complex.

Child neglect and what is sometimes referred to as chronic neglect (repeat instances) is highly correlated with poverty, although most people living in poverty do not neglect their children (Gaudin, 2009)¹⁵⁵. In analyzing the incidents of “chronic neglect” the Children’s Bureau’s

Information Gateway issued a paper¹⁵⁶ that described the stressors on families that came to the attention of CPS due to chronic neglect:

“Several parental stressors are associated with chronic neglect, including poverty, mental health issues, and substance abuse (Tanner & Turney, 2003; Wilson & Horner, 2003). Of all forms of maltreatment, neglect has the strongest relationship to poverty (Loman, 2006). This relationship is not causal but contributory—neglect is strongly associated with measures of socioeconomic disadvantage, which include welfare dependence, homelessness, low levels of education, and single-parent families—as well as limited income.” Poverty can be attributed as a risk factor for neglect; and should not be confused with poverty being neglect.”

Although, families and children living in poverty should not indicate to child welfare that a child is unsafe or that a parent lacks the ability to care for his or her child, AFCARS data shows different measures. In 2019, 63 percent of children were removed from their home in placed in foster care due to neglect. Neglect can indicate different definitions across the country however poverty and parent’s ability to meet the basic needs for a child are indicative in majority of the children who are removed annually from their home in America.

A GAO report¹⁵⁷ indicated that poverty has been attributed as a reason that children are removed from their home and placed with kin caregivers due to their parents unwillingness to provide care and financial problems. Generational poverty or economic conditions has become a consistent reason why grandparents and other kin are caring for children. One report stated that “the economy is a major factor because parents may be unable to keep their jobs or care for themselves ... parents must travel to find employment and leave their children with grandparents.” According to the American Community Survey in 2018, an estimated 19 percent of grandparents who are primary caregivers for children lived below the federal poverty threshold and many struggled to pay their own bills, therefore creating additional financial strain when caring for children.¹⁵⁸

The Temporary Assistance for Needy Families (TANF) program, first and foremost, is also critical in assisting vulnerable families by providing cash assistance so that a struggling family does not get pushed over a financial or emotional cliff. In 1996, when Aid to Families with Dependent Children (AFDC) was converted into TANF, 68 of every 100 poor families received AFDC assistance.¹⁵⁹ By 2018, only 22 of every 100 poor families received a TANF cash assistance.

Since 1996, TANF funds, currently at \$16.5 billion, have lost more than 40 percent of their value due to inflation. In addition, \$300 million in supplemental state grants were cut in 2011.¹⁶⁰ As

TANF funding dwindles and erodes, states may be making the policy choice to deny assistance to single parents, undercut funding for assistance because they are subsidizing costs of child care, or child welfare services, in effect pushing families into the most undesirable and vulnerable situations, which will undercut the well-being of those families and their children. We need to restore TANF, both in funding and in purpose, so that it supports families in staying together, helps parents work while providing their children with needed care, and lifts families and children out of poverty.

The National Academy study highlighted research comparing children whose families had incomes above twice the poverty line during their early childhood with children whose families had incomes below the poverty line during this early childhood period. Those children completed 2 fewer years of schooling; as adults worked 451 fewer hours per year; earned less than one-half as much; received more in food stamps, and were more than twice as likely to report poor overall health or high levels of psychological distress.¹⁶¹ They went on to say:

“The weight of the causal evidence indicates that income poverty itself causes negative child outcomes, especially when it begins in early childhood and/or persists throughout a large share of a child’s life. Many programs that alleviate poverty either directly, by providing income transfers, or indirectly, by providing food, housing, or medical care, have been shown to improve child well-being.”¹⁶²

We have seen in 2020, due to COVID-19, just how disadvantaged minority populations are through the health data provided by the CDC. We also know that these families are more likely to be on the frontlines through service industry jobs risking their health. Despite this risk and service they are suffering disproportionately when it comes to pandemic-related housing issues along with surviving economically when they lose their lower paying jobs due to the pandemic.

There needs to be action on the National Academy of Sciences and their policy recommendations in their report, *A Roadmap to Reducing Child Poverty*. We need to cut child poverty in half within ten years. We need to pursue policy options that can strengthen families by reforming programs such as TANF, addressing the growing homelessness and affordable housing problems, and by building on the original improvements through the Affordable Care Act (ACA) to increase health care coverage and access to vital substance use and mental health services.

The report outlines two packages of policies and programs that would cut child poverty and deep poverty in half over 10 years and boost employment. The “means-tested supports and work package” expands both the Earned Income Tax Credit (EITC) and the Child Dependent Care Tax Credit (CDCTC) along with the Supplemental Nutrition Assistance Program (SNAP) and housing voucher programs. These benefit programs lift millions of children out of poverty in the U.S. already, with the EITC and Child Tax Credit lifting majority of children out of poverty in 2019. SNAP continues to be an effective anti-poverty program for children providing low-income households with providing families the ability to put food on the table monthly.

Recommendations

Short-Term

The new Administration should:

- Make a commitment to lift America’s children out of poverty by cutting child poverty in half within the first year

- Reverse immigration policy by restoring program eligibility for nonqualified legal immigrants in the SNAP, TANF, Medicaid, SSI, and other means-tested federal programs.

Long-Term

Congress and the new Administration should:

- Enact legislation to lift families out of poverty, including such strategies as increasing the minimum wage to \$15
- Increase HUD choice housing vouchers including FUP
- Expand early childhood home visiting programs
- Invest in universal access to high-quality child care and preschool
- Adopt the strategies by the National Academy of Sciences including:
 - Expand the Earned Income Tax Credit (EITC) and the Child Tax Credit (CTC)
 - Expand the Supplemental Nutrition Assistance Program (SNAP) and housing voucher program
 - Expand the Child and Dependent Care Tax Credit (CDCTC)
- Enact paid family and medical leave for all families
- Reauthorize TANF and include poverty reduction of as one of the purposes of TANF as a first step toward TANF reform.

CONCLUSION

This document is intended as a guide with many recommendations which we believe will help children and families across the United States.

However, as we said at the outset, if we fail to fight for a comprehensive approach that reaches beyond narrow funding streams of Title IV-B and IV-E or CAPTA—we will fail. Within child welfare that means being guided by our mission and not just our mission statement. In a sense it means eliminating our need to exist because America’s children and families are doing that much better. That means child welfare groups must reach beyond their specific focus or population and look across the needs of the many families involved with “systems.”

It also means that all of us, formal “child welfare advocates” as well as policymakers, need to build a society that lifts families and communities up by reducing poverty and addressing all the social determinants of health including housing, violence, income inequality and all the things that are embedded in impoverished communities whether they are of color or white or urban or rural or native. And it means once and for all, to live out the true meaning of our creed—that we are all created equal.

FOOTNOTES

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