This is a chapter excerpt from Guilford Publications.
Working with Traumatized Youth in Child Welfare, Nancy Boyd Webb
Copyright © 2006

PART I

THEORETICAL FRAMEWORK AND PRACTICE CONTEXT

CHAPTER 1

The Nature and Scope of the Problem

ANTHONY N. MALUCCIO

The field of child welfare in the United States has historically involved three interrelated goals in its mission:

- Protecting children and youth from actual or potential harm, especially child maltreatment;
- Preserving the family unit, including birth family and/or relatives;
- Promoting child well-being and the development of young people into adults who are able to live independently and contribute to their communities.

These goals—and the resulting policies and programs—have evolved in response to the needs of young people coming to the attention of the public or private child welfare system. Many or most of these youth are traumatized or become traumatized following their entry into out-of-home care. This chapter reviews the needs and situations of such youth; examines the response of the service delivery system; suggests required practice transformations; and considers issues in the preparation of adolescents for independent living.

YOUTH COMING TO THE ATTENTION OF THE CHILD WELFARE SYSTEM

We do not have adequate national data about the number of children and families receiving attention of the child welfare system in the United States. This number probably runs over a million at any given time. We

know that annually over half a million children and adolescents are placed in some form of out-of-home care. This number has been increasing in recent years—apparently as a result of cuts in federal funds for preventive services, in addition to dramatic increases in parental substance abuse, homelessness, and unemployment, especially among ethnic minority groups.

Youth in out-of-home care placement (either family foster care or group care) represent a major group at risk. According to the most recent data available, there were over 520,000 children in out-of-home care as of March 31, 1998 (U.S. Department of Health and Human Services, 1999). Also, the U.S. Department of Health and Human Services (2003) has estimated that in 2001 there were 1,321 (or 1.81%) child fatalities in foster care. Although precise data are not available, it is reported that most children enter foster care because of the consequences of parent-related problems, largely child abuse or neglect (Berrick, Needell, Barth, & Jonson-Reid, 1998). In addition, increasing proportions of children with special problems are entering care. These include children with special physical or developmental needs; children with HIV infection; infants born with crack cocaine addiction or other effects of exposure to substance use; children from poor or multiproblem families; and/or children with emotional problems (see, e.g., Dore, 1999).

The proportion of adolescents in out-of-home care has increased rapidly since the 1980s, as the permanency planning movement initially resulted in keeping younger children out of care, reuniting them with their biological families following placement, or placing them in adoption or other permanent plans (Maluccio, 1998). Older youth in placement or making the transition out of care are especially vulnerable and require extensive help. Most of them have entered care because of abuse and neglect, including sexual abuse, plus exposure to and involvement in multiple incidents of violence and other traumatic experiences. Many have lived in numerous out-of-home placements or have been returned home and removed repeatedly (Pecora, Whittaker, Maluccio, & Barth, 2000). Moreover, many of them anticipate the future experience of leaving the child welfare system as yet another separation or rejection in their young lives.

A disproportionate and expanding number of children, youth, and families of color are coming to the attention of child welfare services. Unfortunately, there is substantial evidence that minority youth who enter the child welfare system are at greater risk for poor outcomes than their white counterparts (see Jackson & Brissett-Chapman, 1997). In addition, although they are disproportionately represented in foster care and in the child welfare system in general, young people of color receive inadequate as well as differential treatment. Research has found that "children of color and their families experience poorer outcomes and receive fewer services than their [white] counterparts" (Courtney et al., 1996, p. 99).

Another risk factor for young people entering the child welfare system is exposure to substance abuse and/or violence at home and at school, as well as in the community in general. Family violence has a direct impact on the development of attention and conduct problems in both boys and girls (Becker & McCloskey, 2002). In addition to its impact on a young person, violence impedes a parent's ability to meet his or her child's needs. In extreme cases, the result is incarceration of a parent, which provokes further traumatic stress in the child (Smith, Krisman, Strozier, & Marley, 2004).

Young people living with parents who abuse substances are at higher risk for physical abuse and neglect. Over 15 years ago, the National Committee for Prevention of Child Abuse (1989) estimated that 9–10 million children are affected by parental substance abuse, and that 675,000 children are maltreated each year by caretakers addicted to alcohol and other drugs. These numbers have undoubtedly increased since then. Among confirmed cases of child maltreatment nationwide, from 40% to 80% involve substance abuse problems that interfere with parenting (Child Welfare League of America, 1998).

When young people are cared for by parents with substance abuse problems, they are often exposed to a number of risks in addition to child maltreatment, including these (Maluccio & Ainsworth, 2003; Tracy, 1994):

- Chaotic and often dangerous neighborhoods.
- Poverty and homelessness or unstable housing.
- Neglect of the youth's basic needs.
- Lack of an extended family and community support system.
- A parent or parents with poor parenting skills and few or no role models for effective coping.
- Placement in out-of-home care.

RESPONSE BY THE SERVICE DELIVERY SYSTEM

Various programs have evolved in response to the needs of the increasing numbers of youth and their families coming to the attention of child welfare, mental health, and correctional agencies. These include both *traditional* services and *innovative* programs. Traditional services include kinship care, family foster care, residential group care, and adoption. Especially noteworthy is the increase in use of kinship care throughout the country. Although there are obvious advantages to keeping children within the context of their families of origin, we should note that kinship care raises numerous issues that should be considered, including questions about funding, relationships between parents and relatives, and relationships between families and agencies (Hegar & Scannapieco, 1999; Webb, 2003). "Achieving successful outcomes for children in kinship care

requires . . . philosophical shifts, policy changes, and practice efforts that support kin caregivers and children" (Lorkovich, Picolla, Groza, Brindo, & Marks, 2004, p. 159). In this regard, it is noteworthy that there are standards and measures for kinship care assessment (Chipman, Wells, & Johnson, 2002).

In addition to such traditional services, innovative programs have evolved in the field of child welfare. These include family preservation, treatment foster care, family reunification, independent living programs, family group decision making, shared family care, and wraparound services. Evaluative studies indicate that these innovations are effective in promoting children's development, especially if the programs are adequately funded and if practitioners and their supervisors are fully trained and supported in their work (Maluccio, Ainsworth, & Thoburn, 2000).

Mental health services have also been developed on behalf of children and families at risk. In situations involving trauma, the fields of child welfare and mental health are becoming much more closely integrated, in contrast to their earlier history; at least, they are collaborating more actively both in provision of services to children and their families, *and* in efforts to influence preventive programs as well as state and federal legislation. We see such collaboration in at least two areas.

First, child welfare and mental health agencies collaborate in planning joint training programs for their staffs, particularly in the area of trauma (such as the trauma of physical and emotional abuse). An innovative feature of some of these programs is the involvement of especially competent and effective workers—and also parents and older adolescents—as trainers or consultants. Such programs also emphasize helping caseworkers to identify children's basic needs, including mental health needs, when they develop case plans and provide services.

Second, in many communities child welfare workers and mental health practitioners participate jointly in case conferences and case planning for parents and/or children with substance abuse, HIV/AIDS, and multiple health or mental health problems. A special feature of these programs is that child welfare and mental health workers build into the service plan the requirement to keep each other informed of progress in each case; in addition, they schedule periodic follow-up conferences to review and revise treatment plans. Moreover, the services are typically provided by one or another of the agencies involved, rather than through referring a case to still another agency that is not known to the clients. The latter approach has contributed to the high dropout rate of child welfare clients referred to mental health clinics; when a family is referred to an unknown agency with a long waiting period, its members lose interest or motivation by the time an appointment becomes available.

Although these innovations are noteworthy, there are other populations for whom greater and better collaboration is required. These

include (1) children with developmental disabilities; (2) children with incarcerated parents; and (3) children from families affected by substance abuse.

The occurrence of developmental disabilities in children may be related to trauma caused by accidents or by child abuse, especially during the first year. An estimated 25% of all developmental disabilities are the result of child maltreatment (Maluccio, Pine, & Tracy, 2002). Children with disabilities are at high risk of being abused or neglected and thus experiencing further trauma—partly because their need for special care may be overwhelming for their families or communities. The families, in particular, may be suffering from preexisting environmental problems and life pressures. Practitioners should be aware of the educational rights to which children with disabilities and their families are entitled through the Individuals with Disabilities Education Act, P.L. 101-476 (Altshuler & Kopels, 2003).

In regard to children of incarcerated parents, we need to pay attention to the major rise in the prison population—another serious risk factor for children and families coming to the attention of the child welfare system (Smith et al., 2004). Current estimates are that nearly 2 million children and youth in the United States have an incarcerated parent. Furthermore, the number of women in prison has risen dramatically in recent years. Many of these women abuse substances and have children at home or in foster care. The impact of separation from their mothers often leads to anxiety, low self-esteem, and depression in these children.

Children who witness violence are likely to be overrepresented in families with substance abuse and incarceration. Here again, there are few services for these children—services that could be effectively provided through collaboration among prison, child welfare, and mental health staffs.

Service needs for families with substance abuse extend beyond traditional treatment programs and child welfare services into a variety of additional services in the areas of housing, early childhood intervention, vocational programs, and health and mental health treatment. Especially required—though difficult to implement successfully—are programs enabling mothers or fathers to learn to parent again while simultaneously learning to adopt and maintain a sober lifestyle.

PRACTICE TRANSFORMATIONS

Establishing and maintaining the kinds of programs described in the preceding section require transformations in child welfare as well as mental health practice. Accordingly, as delineated by Pecora et al. (2000, pp. 14–

20), various service reforms have been implemented—or at least initiated—in recent years. The major ones are highlighted in this section.

"Safety planning"—that is, establishing a safe working environment for child, family, and staff members in each case situation—has emerged as a basic practice approach particularly in family situations involving potential risks. The objectives are (1) to protect the child as well as other family members; and (2) to provide every child with a "forever home" through family preservation, reunification, termination of parental rights and adoption, or long-term foster care with guardianship—in that order of priority.

Safety planning is promoted through the use of community-based and neighborhood-based programs, school-based services, wraparound services, youth employment programs, and managed care techniques, thus broadening the mix of service options in many communities. These innovations are noteworthy, as they enable child welfare agencies to become more fully integrated into the community and better positioned to call upon economic, educational, mental health, housing, vocational, education, and other resources for assistance in achieving the shared outcomes they have created for children and parents.

Also evolving are "systems of care" approaches in the field of mental health. Such approaches are intended to organize and deliver services on the basis of three core practice emphases: child- and family-centered, community-based, and culturally competent (Stroul & Friedman, 1996). By implementing these core approaches, agencies can reduce barriers to service, involve parents and children more extensively, and promote the coordination of services. In the field of child welfare, the use of a public–private partnership model of service delivery promotes collaboration and service effectiveness (Lewandowski & GlenMaye, 2002).

In line with the emphasis on service coordination, child welfare agencies are increasingly collaborating with mental health as well as public health agencies. Such systems of care help "to coordinate and integrate mental health services for children and youths, while simultaneously managing existing funding sources more effectively" (Anderson, McIntyre, Rotte, & Robertson, 2002, p. 514). For example, models of child abuse prevention and family support involve public health nurses, social workers, and/or other practitioners (e.g., Olds & Kitzman, 1995). These programs are utilized particularly for families with HIV/AIDS and for children and youth with special needs. They hold promise of more extensive partnerships between child welfare and public health agencies; they also have the potential to strengthen preventive services in the area of child maltreatment in nonstigmatizing ways.

As previously noted, the increase in the numbers of families with substance abuse issues has created a need for additional prevention and treatment programs. Partnerships among child welfare, early childhood, edu-

cation, mental health, primary health care, and substance abuse treatment services are crucial.

PREPARATION FOR INDEPENDENT LIVING

As noted earlier in this chapter, the proportion of adolescents in family foster care and residential treatment in the United States has increased rapidly since the 1980s. Most of these adolescents are discharged to another plan upon reaching majority age at 18 —typically, to some form of independent living, though it is unrealistic in contemporary society to expect them to be truly independent at such an age.

Evaluative studies regarding the functioning of these young people, in fact, have reported largely negative findings. First, foster parents and social workers have consistently reported that most adolescents approaching emancipation are unprepared for independent living (Maluccio et al., 2000). Second, follow-up studies of young people who grew up in out-of-home placement have pointed to their lack of preparation for life after foster care. Third, it has been found that a high number of homeless persons have a history of foster care placement, with some having been placed in both foster family and residential settings. For instance, Roman and Wolfe (1997) found that persons with a history of foster care placement were overrepresented in the homeless population.

The challenges in preparation for independent living include preparing youth earlier in their placement; offering better vocational assessment and training; providing adequate health care; helping youth to develop life skills; and maintaining supports for young people as they move into adulthood (Nollan et al., 2000). Such a panoply of services is essential, as adolescents in foster care generally have limited supports in their families and social networks and are often emotionally, intellectually, and/or physically delayed from a developmental perspective.

It should also be noted that the very concept of "independent living" has been criticized, especially since it creates unrealistic and unfair expectations of adolescents who have left or are preparing to leave foster care (Maluccio et al., 2000). We have proposed, instead, the concept of "interdependent living" in practice with young people in out-of-home care. Such a concept reflects the assumption that human beings are interdependent, "that is, able to relate to—and function with—others, using community influences and resources, being able to carry out management tasks of daily life and having a productive quality of life through positive interactions with individuals, groups, organizations, and social systems" (Maluccio et al., 2000, p. 88). Practice approaches that emphasize the value of interdependence serve to empower young people who are making the transition from foster care (Propp, Ortega, & NewHeart, 2003).

CONCLUSION

Recent decades have seen a substantial increase in both the number and variety of child welfare services, due in large measure to the contributions of child welfare workers, mental health practitioners, foster parents, child care workers, and other community partners and professionals. As a result, we have considerable knowledge of how traumatized children and youth and their families can be effectively helped at both the treatment and prevention levels. In addition, there are examples of excellent programs that can be adapted in other communities.

We also know that the field of child welfare has for too long been hampered by federal and state funding policies that have rewarded the "wrong" program emphases, such as completing child abuse investigations (rather than preventing the need for new ones) and keeping children in foster care (instead of securing more permanent homes for them). With the renewed emphasis on preserving families for children, agencies are striving to align funding priorities and performance incentive mechanisms to support preventive services along with greater program flexibility.

Such emphasis is leading to decreased use of unnecessary out-of-home care; increased use of services that support preserving families or returning young people to their own homes; and optimized collaboration between the child welfare and mental health service delivery systems. At the same time, it is essential that we continue to persist in working together to meet recurring challenges—especially in regard to funding and politics—in the decision, implementation, and evaluation of such services.[1]

ACKNOWLEDGMENTS

Sections of this chapter have been adapted from Maluccio, Pine, and Tracy (2002) and Maluccio, Ainsworth, and Thoburn (2000). Copyright 2002 by Columbia University Press, and copyright 2000 by the Child Welfare League of America, respectively. Adapted by permission.

REFERENCES

Altshuler, S. J., & Kopels, S. (2003). Advocating in schools for children with disabilities: What's new with IDEA? *Social Work*, *48*, 320–329.

Anderson, J. A., McIntyre, J. S., Rotte, K. I., & Robertson, D. C. (2002).

[1]Following a year of deliberations, the Pew Commission on Children in Foster Care released on May 18, 2004 its recommendations for reforming the nation's child welfare system (see www.socialworkers.org/advocacy/updates/082003_a.asp).

Developing and maintaining collaboration in systems of care for children and youths with emotional and behavioral disabilities and their families. *American Journal of Orthopsychiatry*, *72*, 514–525.

Becker, K. B., & McCloskey, L. A. (2002). Attention and conduct problems in children exposed to family violence. *American Journal of Orthopsychiatry*, *72*, 83–91.

Berrick, J. D., Needell, B., Barth, R. P., & Jonson-Reid, M. (1998). *The tender years: Toward developmentally sensitive child welfare services for very young children*. New York: Oxford University Press.

Child Welfare League of America. (1998). *Breaking the link between substance abuse and child maltreatment: An issue forum*. Washington, DC: Author.

Chipman, F., Wells, S. J., & Johnson, M. A. (2002). The meaning of quality in kinship foster care: Caregiver, child and worker perspectives. *Families in Society: The Journal of Contemporary Human Services*, *83*, 508–520.

Courtney, M. E., Barth, R. P., Berrick, J. D., Brooks, D., Needell, B., & Park, L. (1996). Race and child welfare services: Past research and future directions. *Child Welfare*, *75*, 99–137.

Dore, M. (1999). Emotionally and behaviorally disturbed children in the child welfare system: Points of intervention. *Children and Youth Services Review*, *66*, 335–348.

Hegar, R. L., & Scannapieco, M. (Eds.). (1999). *Kinship foster care: Policy, practice, and research*. New York: Oxford University Press.

Jackson, S., & Brissett-Chapman, S. (Eds.). (1997). Perspectives in serving African American children, youths, and families [Special issue]. *Child Welfare*, *76*, 3–278.

Lewandowski, C. A., & GlenMaye, L. F. (2002). Teams in child welfare settings: Interprofessional and collaborative processes. *Families in Society: The Journal of Contemporary Human Services*, *83*, 245–256.

Lorkovich, T. W., Picolla, T., Groza, V., Brindo, M. E., & Marks, J. (2004). Kinship care and permanence: Guiding principles for policy and practice. *Families in Society: The Journal of Contemporary Human Services*, *85*, 159–164.

Maluccio, A. N. (1998). Assessing child welfare outcomes: The American perspective. *Children and Society*, *12*, 161–168.

Maluccio, A. N., & Ainsworth, F. (2003). Drug use by parents: A challenge for family reunification practice. *Children and Youth Services Review*, *25*, 511–533.

Maluccio, A. N., Ainsworth, F., & Thoburn, J. (2000). *Child welfare outcome research in the United States, United Kingdom, and Australia*. Washington, DC: Child Welfare League of America Press.

Maluccio, A. N., Pine, B. A., & Tracy, E. M. (2002). *Social work practice with families and children*. New York: Columbia University Press.

National Committee for Prevention of Child Abuse. (1989). *Fact sheet: Substance abuse and child abuse*. Chicago: Author.

Nollan, K. A., Wolf, M., Ansell, D., Burns, J., Barr, L., Copeland, W., & Paddock, G. (2000). Ready or not: Assessing youths' preparedness for independent living. *Child Welfare*, *79*, 159–176.

Olds, D. L., & Kitzman, H. (1995). Review of research on home visiting for pregnant women and parents of young children. *The Future of Children: Home Visiting*, *3*, 53–92.

Pecora, P. J., Whittaker, J. K., Maluccio, A. N., & Barth, R. P. (2000). *The child welfare challenge: Policy, practice, and research* (2nd ed.). New York: Aldine de Gruyter.

Propp, J., Ortega, D. M., & NewHeart, R. (2003). Independence and interdependence: Rethinking the transition from "ward of the court" to adulthood. *Families in Society: The Journal of Contemporary Human Services*, *84*, 259–266.

Roman, N. P., & Wolfe, P. B. (1997). The relationship between foster care and homelessness. *Public Welfare*, *55*, 4–9.

Smith, A., Krisman, K., Strozier, A. L., & Marley, M. (2004). Breaking through the bars: Exploring the experiences of addicted incarcerated parents when children are cared for by relatives. *Families in Society: The Journal of Contemporary Human Services*, *85*, 187–195.

Stroul, B. A., & Friedman, R. M. (1996). The system of care concept and philosophy. In B. A. Stroul (Ed.), *Children's mental health: Creating systems of care in a changing society* (pp. 3–22). Baltimore: Brookes.

Tracy, E. M. (1994). Maternal substance abuse: Protecting the child, preserving the family. *Social Work*, *39*, 534–540.

U.S. Department of Health and Human Services, Administration for Children and Families. (1999). *The AFCARS report: Current estimates as of January 1999.* Retrieved from www.acf.dhhs.gov/programs/chdata (January 5, 2000).

U.S. Department of Health and Human Services, Administration for Children and Families. (2003). *Child maltreatment–2001*. Washington, DC: U. S. Government Printing Office.

Webb, N. B. (2003). *Social work practice with children* (2nd ed.). New York: Guilford Press.

Copyright © 2006 The Guilford Press. All rights reserved under International Copyright Convention. No part of this text may be reproduced, transmitted, downloaded, or stored in or introduced into any information storage or retrieval system, in any form or by any means, whether electronic or mechanical, now known or hereinafter invented, without the written permission of The Guilford Press.

Guilford Publications
72 Spring Street
New York, NY 10012
212-431-9800
800-365-7006
www.guilford.com