



The *CHILD*
in Child Welfare and the Courts

**New York State Court
and Child Welfare 2006 Data Book**

New York State Permanent Judicial Commission on Justice for Children

New York State Permanent Judicial Commission on Justice for Children

Chair: Judith S. Kaye, Chief Judge of the State of New York and the Court of Appeals

Executive Director: Sheryl Dicker

MISSION STATEMENT:

The Commission was established to improve the lives and life chances of children affected by New York State's Court system.

Richard J. Barlett, Esq.
Bartlett, Pontiff, Steward, Rhodes & Judge

Dr. Steven Blatt
Associate Professor of Pediatrics
SUNY Upstate Medical University

Larry Brown
Executive Deputy Commissioner
NYS Office of Children and Family Services

Sheryl Browne-Graves, Ed.D.
Department of Education Foundations
Hunter College

Geoffrey Canada
Director
Rheedlen Centers for Children & Families

Lizette A. Cantres
Attorney in private practice
Westchester County

Dr. Michael I. Cohen
Chairman, Department of Pediatrics
Montefiore Medical Center

Honorable Joan O. Cooney
Supervising Judge
Family Court, Ninth District

Honorable Monica Drinane
Bronx Family Court

Nancy Dubler
Director
Division of Legal & Ethical Issues in Health Care
Montefiore Medical Center

Honorable Lee Elkins
Kings County Family Court

Honorable Michael Gage
Retired Administrative Judge
New York City Family Court

Honorable Richard N. Gottfried
Chair
Assembly Standing Committee on Health

Mary F. Kelly, Esq.
Kelly & Knaplund

Honorable Susan K. Knipps
Supervising Judge
New York County Court

Jane Knitzer, Ed.D.
Director
National Center for Children in Poverty

Honorable Joseph Lauria
Administrative Judge
New York City Family Court

Ian G. MacDonald, Esq.
Dutchess County Attorney's Office, retired

Commissioner John Mattingly
NYC Administration for Children's Services

Honorable Sondra Miller
Justice of the Appellate Division, 2nd Department

Elba Montalvo
Executive Director
Committee for Hispanic Children and Families

Honorable Nicolette M. Pach
Retired Judge
Suffolk County Family Drug Treatment Court

Jim Purcell
Executive Director
Council of Family and Child Caring Agencies

Senator Mary Lou Rath
61st District, Genesee County

Honorable Clark Richardson
Supervising Judge
Bronx Family Court

Honorable Anthony Sciolino
Monroe County Family Court

Charles S. Sims, Esq.
Proskauer Rose

Assemblyman William Scarborough
29th District, Queens County

Professor Jane Spinak
Columbia Law School

Honorable Sharon Townsend
Administrative Judge
8th Judicial District

Michael Weiner
Commissioner
Erie County Department of Social Services

Lucia B. Whisenand, Esq.
Law Guardian
Onondaga County



The *CHILD* in Child Welfare and the Courts

**New York State Court
and Child Welfare 2006 Data Book**

Project Directorship

NYS Permanent Judicial Commission on Justice for Children

Sheryl Dicker

Executive Director

Azra Farrell

Deputy Director

Project Management

NYS Council on Children and Families

Toni Lang

NYS KIDS COUNT/KWIC Project Director

Robin Miller

NYS KIDS COUNT/KWIC Project Assistant



The CHILD in Child Welfare and the Courts 2006 Data Book has been printed on recycled paper.

Project Team Members



Maria Barrington

Division of Court Operations, Unified Court System

Susan Bubb

Project Consultant

Carol Greco Champitto

Division of Technology, Unified Court System

Lillian Denton

Office of Children and Family Services

Azra Farrell

Permanent Judicial Commission on Justice for Children

Virginia Gippetti

New York City Family Court

Toni Lang

Council on Children and Families

Wing Leung

Cogent Technologies

Paul Marrano

Cogent Technologies

Robin Miller

Council on Children and Families

Special thanks are extended to the Unified Court System
and Office of Children and Family Services staff who contributed to the success of this project.

Message from Sheryl Dicker



September 2006

Dear Friends,

We are pleased to present “The CHILD in Child Welfare and the Courts,” the nation’s first publication of county-by-county data collected by the court and child welfare systems. This book is the product of a strong collaboration among the New York State Courts, the New York State Office of Children and Family Services and the New York Council on Children and Families all working together to improve outcomes for children in our child welfare system.

This book provides a valuable resource for dedicated professionals working in our court and child welfare systems to better understand the available information and trends concerning abused and neglected children and their families. Using the current data from both systems will be a powerful tool to enhance collaborations between the courts and local departments of social services to better serve our state’s most vulnerable children.

The Permanent Judicial Commission on Justice for Children’s Court Improvement Project developed and spearheaded this initiative and also secured funding from the Pew Charitable Trusts’ Fostering Results project. This publication would not have been possible without the dedication and leadership of Toni Lang and the staff of the New York State Council on Children and Families.

Very truly yours,

A handwritten signature in blue ink that reads "Sheryl Dicker". The signature is fluid and cursive, with the first name being more prominent.

Sheryl Dicker
Executive Director
NYS Permanent Judicial Commission on Justice for Children

Joint Message from Commissioner John A. Johnson and Deborah A. Benson



September 2006

Dear Colleagues,

It is a pleasure to join with the Permanent Judicial Commission on Justice for Children in presenting this first edition of *The CHILD in Child Welfare and the Courts*. This product is the result of a collaborative effort among the Commission, Office of Court Administration, New York State Office of Children and Family Services and Council on Children and Families. The aim of the project is to use data focusing on the child while providing a broader context of well-being to inform policy development, planning and accountability as a means to improve outcomes for children and youth involved with child welfare and the courts.

The Commission, OCFS and the Council are all committed to promoting the well-being of children in or at-risk of foster care. The common goals of ensuring that children are safe, that they reside in loving homes and that they develop to their full potential have contributed to the success of this partnership.

We look forward to continuing our work together on behalf of all New York State's children.

Sincerely,

John A. Johnson
Commissioner
NYS Office of Children and Family Services

Deborah A. Benson
Acting Executive Director
Council on Children and Families



The Permanent Judicial Commission on Justice for Children is pleased to publish the first ever county-by-county child welfare data book that is derived from data collected and compiled by the New York Unified Court System and the New York State Office on Children and Family Services. The goals of the data book are to provide professionals and advocates in the child welfare and court systems with common child-oriented data that are specific to each county, and to bring awareness to the public, the media, legislators, and other systems serving children who come before Family Courts.

The Commission is a partner of Fostering Results, a national non-partisan education and outreach project to raise awareness of the need for improved court oversight of foster care cases and federal financing reform. The Pew Charitable Trusts supports both Fostering Results and the Pew Commission on Children in Foster Care. On May 18, 2004, the Pew Commission on Children in Foster Care released specific recommendations for reform to which this dissemination of child-oriented, child welfare and court data is responsive. These recommendations include:

- Adoption of court performance measures by dependency courts to ensure that they can track and analyze their caseloads, increase accountability for improved outcomes for children, and inform decisions about the allocation of court resources;
- Incentives and requirements for effective collaboration between courts and child welfare agencies on behalf of children in foster care and continue the Commission's groundbreaking collaborative work;
- A strong voice for children and parents in court and effective representation by better trained attorneys and volunteer advocates including our development of standards for CASA; and
- Leadership from Chief Justices and other state court leaders in organizing their court systems to better serve children, provide training for judges, and promote more effective standards for dependency courts, judges and attorneys.

The Commission is grateful for the generous support from Fostering Results for the publication of this data book and for the collective efforts of the NYS Office of Children and Family Services, the Office of Court Administration, the Council on Children and Families and Commission staff. This publication takes advantage of the familiarity and format of the NYS Touchstones/KIDS COUNT efforts of the Council. The Council, being part of the state-level KIDS COUNT network, funded by the Annie E. Casey Foundation, publishes annual data books on the health, education and well-being of children and youth in New York State. Together these efforts provide a broader context of well-being for policy development, planning and accountability for children and youth and specifically for children and youth in the child welfare and court systems.

The Commission is proud to present this data book and hopes that the data presented will be used by stakeholders within the courts and child welfare systems to improve the safety, permanency and well-being of children. It is further our goal that this data will become a tool to help New York achieve safety, permanency and well-being of all children whose lives are affected by the court and child welfare systems.

The Data Book Layout



PART I presents an Introduction that features a descriptive essay about the Commission; the risk and protective factors associated with child abuse and neglect; some of the most common physical, psychological, behavioral, and societal consequences of child abuse and neglect; and children in foster care. Together these sections demonstrate the importance of looking within data to gain a glimpse of the children involved in the child welfare and court systems and to use that data to improve the lives and life chances of those children.

PART I also presents A Progression of Data-driven Efforts to Improve Outcomes for Children, the New York State Touchstones Framework and a New York State Fact Sheet about children and youth involved in the child welfare and court systems. This information helps explain how this project fits within existing efforts to advance the use of children's health, education and well-being indicators as a tool for policy development, planning, and accountability. The New York State Touchstones vision – that all children, youth and families will be healthy and have the knowledge, skills and resources to succeed in a dynamic society – is universal for children and youth living in single-parent families, two-parent families, foster homes or any other living arrangement. The Fact Sheet demonstrates the importance of addressing the needs – including, safety, permanency and well-being – of New York State children involved in the child welfare and court systems.

PART II presents Indicator Profiles organized by the NYS Touchstones goals, objectives and life areas. Indicator Profiles present New York State, New York City, Rest of State (NYS minus NYC), and each of New York's 62 counties data for each indicator. Indicator profiles present the most current year along with a comparison year thereby allowing examination of the long-term trend.

(For year-by-year data, go to KWIC at <http://www.nyskwic.org>.) Narratives accompany each indicator to provide the respective definition, significance and current findings.

PART III presents Region Profiles for New York State, New York City, Rest of State and each on New York's 62 counties. For each of these regions, the Region Profile provides the most current data available and an arbitrary comparison year data along with the New York State rate for indicators that share a common theme or topic, specifically child welfare for this publication. There are two other Region Profiles currently available on KWIC: the KWIC Profile that provides a snapshot of the overall health, education and well-being of children, youth and families in New York State; and the Maternal/Child Health Profile that provides a snapshot of the health and well-being of mother and child, including pregnancy, birth, prenatal care, birth weight and gestation, and infant mortality data.

PART IV presents New York State data related to the federal Child and Family Services Review (CFSR). The CFSR was designed to ensure the State child welfare agency practice is in conformity with Federal child welfare requirements, to determine what is actually happening to children and families as they are engaged in State child welfare services, and to assist States to enhance their capacity to help children and families achieve positive outcomes.

GLOSSARY presents an alphabetized list of terms and indicators presented in the CHILD in Child Welfare and the Courts publication.

Table of Contents



Message from Sheryl Dicker	3
Joint Message from Commissioner John A. Johnson and Deborah A. Benson	4
Welcome	5

PART I—Introduction

New York State 2004 Fact Sheet	10
Introduction	11
New York State Permanent Judicial Commission on Justice for Children	12
Risk and Protective Factors for Child Abuse and Neglect	14
Long-term Consequences for Child Abuse and Neglect	17
Children in Foster Care	22
Conclusion	25
Progression of Data-driven Efforts to Improve Outcomes for Children	31
New York State Touchstones	32

PART II—Indicator Profiles

Demographics

NYS Population by Race and Hispanic Origin and Age	38
--	----

Economic Security

Children and Youth Living Below Poverty	42
---	----

Physical and Emotional Health

Adolescent Births and Pregnancies by Maternal Age	45
Infant Mortality (Three-year Average)	50
Low Birthweight Births and Premature Births by Maternal Age	53

Education

Annual Dropouts—Public Schools	58
--	----

Citizenship

Adolescent Arrests for Property and Violent Crimes	61
Adolescent Arrests for Drug Use/Possession/Sale/DUI	66
Assaults—Hospitalizations Resulting from Assault (Three-year Average)	68
Driving While Intoxicated Arrests	70
Persons in Need of Supervision (PINS) Cases Opened for Services	72

Community

Firearm Related Index Crimes	76
Property and Violent Index Crimes Known to the Police	78
Resident Civilian Unemployment	80

Table of Contents



Family

NYS Child Welfare and Court Data Sources	84
NYS Definitions of Abused, Neglected and Maltreated Child	85
A Child's Journey Through the Child Welfare System	86
Child Abuse and Maltreatment— Indicated Reports of Child Abuse and Maltreatment	88
Child Abuse and Maltreatment— Children and Youth in Indicated Reports	90
Child Abuse and Maltreatment— Resulting in Removal of Child	92
Child Abuse and Maltreatment— Resulting in Court Cases	96
Foster Care— Children and Youth In Care.	98
Foster Care— Children and Youth In Care by Placement Type	100
Foster Care— Children and Youth Admitted to Foster Care	102
Foster Care— Children and Youth Admitted by Age	104
Foster Care— Children and Youth Admitted by Race/Ethnicity	107
Foster Care— Children and Youth Admitted by Placement Type	110
Foster Care— Children and Youth Discharged from Foster Care	112
Foster Care— Children and Youth Discharged by Placement Type	114
Foster Care— Terminated Parental Rights Judgments	118
Foster Care— Parental Rights Surrendered	122
Foster Care— Adoption Milestones	124

PART III—Region Profiles

New York State Map with County Names	131
New York State Profile	132
New York City Profile	134
New York City County Profiles	136-145
Rest of State Profile	146
Rest of State County Profiles	148-261

PART IV—Child and Family Services Review (CFSR)

CFSR Background	265
CFSR Outcomes and National Standards	266
CFSR Background for New York State	267
CFSR Safety Measure— Recurrence of Maltreatment for Children	268
CFSR Safety Measure— Maltreatment of Children in Foster Care	269
CFSR Permanency Measure— Two or Fewer Foster Care Placements While In Care Less Than One Year	270
NYS Alternative Permanency Measure— Children and Youth with Permanent Exits from Foster Care	272
NYS Alternative Permanency Measure— Children and Youth Re-Entering Foster Care within 24 Months	274

Glossary	276
--------------------	-----



PART I

Introduction

This section starts with facts about children and youth involved in the New York State child welfare and court systems. The pieces that follow help explain how this project came about, provide research related to children and youth within the child welfare and court systems, and illustrate how this project fits within other New York State data-driven efforts.



Child Abuse and Maltreatment

Reports of Child Abuse and Maltreatment

- The New York State Central Register received 142,130 reports of suspected child abuse and maltreatment.
- Three out of ten reports (43,175) were indicated.
- The percentage of indicated reports of child abuse and maltreatment was somewhat higher in New York City (32.9%) compared to Rest of State (29.3%). This pattern is consistent with that found in 2000 (35.1% vs. 29.8%) but the difference between the rates decreased.

Children in Indicated Reports

- The number of unique¹ children and youth in indicated reports of child abuse and maltreatment was 63,877.
- Nearly 14 out of every 1,000 children and youth ages 0 to 17 years were involved in indicated reports of child abuse and maltreatment.
- The rate of child abuse and maltreatment was greater in Rest of State compared to New York City (15.2 vs. 11.3/1,000 children 0-17 years). This pattern is consistent with that found in 2000 (13.6 vs. 13.1/1,000 children) but the difference between the rates increased.

Children Removed from their Homes

- 5,356 children and youth with petitions filed were removed from their homes at or before the petition filing date.
- 1,107 children and youth with petitions filed were removed from their homes at the initial court hearing.

Types of Child Abuse and Maltreatment

TYPE	PERCENT ²
Neglect/Deprivation of Neccessities	91%
Physical Abuse	12%
Sexual Abuse	4%
Psychological/Emotional Maltreatment	1%
Medical Neglect	4%
Other Types	25%

Mortalities

- There were 77 children in indicated reports with fatality allegation and substantiated determination. This translates to a rate of 1.64 children per 100,000 children 0 to 17 years in the general population.

Foster Care

Children in Foster Care

- 26,108 children/youth were in foster care, translating to a rate of 4.5 per 1,000 children and youth 0 to 21 years.
- The majority of children in care were in home care (49.2%), followed by congregate care (25.9%), relative care (19.2%) and other (5.8%).

Children Admitted to Foster Care

- 12,494 children and youth were admitted to foster care.
- Nearly 3 out of 10 children (29.7%) entering foster care were under 5 years of age and 1 out of 4 children was 15 to 17 years of age.
- A disproportionate number of African American children entered foster care (41.2% of all children admitted) based on the racial distribution of the state.

Children Discharged from Foster Care

- 15,513 children and youth – or 37.3 percent of all children who were in foster care at any time during the year – were discharged from foster care.
- There were 3,473 discharges to adoption, representing 22.4 percent of all discharges.

Parental Rights Judgments

- 2,659 terminated parental right judgments – or 61.3 percent of all TPR judgments – resulted in the termination of parental rights.
- 1,565 surrendered parental rights judgments – or 82.8 percent of all surrendered judgments – resulted in the surrender of parental rights.

Two or Fewer Placements for Children In Care less than 1 Year

- 12,484 children and youth – or 91.4 percent – of children in foster care less than one year had two or fewer placements.

¹ Unique child refers to an individual child who is included in an indicated report of abuse or maltreatment. The unique number, within New York City and Rest of State, will count a child only once during a year even if that child has more than one indicated abuse or maltreatment.

² Percentages based on children with substantiated allegations in indicated reports. Percentages total greater than 100 percent since children can experience more than one type of abuse or maltreatment.



The Permanent Judicial Commission on Justice for Children (Commission) was established to improve the lives and life chances of children affected by New York State's court system. *The CHILD in Child Welfare and the Courts* project aims to propel data-driven efforts to improve outcomes for children and youth involved with child welfare and the courts by focusing on the child and by providing a broader context of well-being for policy development, planning, and accountability. This effort brings data collected by the New York State Family Courts and the New York State Office of Children and Family Services together and takes advantage of the familiarity and usability of the New York State Touchstones/KIDS COUNT format and the data disseminating abilities of KWIC.

To put this project in context, this review first introduces the Commission and its challenges, goals and accomplishments. The second section, focusing on risk and protective factors associated with child abuse and neglect, is an excerpt from the U.S. Department of Health and Human Services' *Emerging Practices in the Prevention of Child Abuse and Neglect* (Thomas et al., 2003). The third section, an excerpt from *Long-term Consequences of Child Abuse and Neglect* (Child Welfare Information Gateway, 2006), provides an overview of some of the most common physical, psychological, behavioral, and societal consequences of child abuse and neglect, while acknowledging that much crossover among categories exists. The fourth section focuses on children in foster care and largely relies on a compilation of research conducted by the Commission and published by the National Center for Children in Poverty (Dicker, Gordon & Knitzer, 2001). Together these sections demonstrate the importance of looking within data to gain a glimpse of the children involved in the child welfare and court systems and to use that data to improve the lives and life chances of those children.

Meet the Commission



The Commission has emerged as a statewide and national pacesetter for court-based innovation and judicial leadership on behalf of children and those who care for them. The Commission has a unique position as the nation's first interdisciplinary children's Commission based in the judiciary and has harnessed the authority and prestige of the judiciary to launch and sustain projects and to shape policy that improve court proceedings and maximize the well-being of children in foster care. The permanent nature of the Commission encourages creativity by providing opportunities to explore uncharted terrain, test new practices, create new resources and cultivate new relationships.

The Commission has long recognized the value in partnering with all those who work to promote better outcomes for children. Commission members include judges as well as lawyers, advocates, child welfare administrators, physicians, legislators and state and local officials. All of the Commission's initiatives encourage creating collaborations to affect change. The Commission has worked closely with national leaders in the fields of child welfare, child development, early intervention, early childhood education and special education. By conducting independent research and utilizing cutting-edge child welfare and early childhood researchers, the Commission has enhanced the lives of children in foster care. In fact, collaborations and commitment to research-driven, court-based initiatives have become hallmarks of the Commission's accomplishments.

The focus of the Commission's name – *Justice for Children* – exemplifies a limitless, lofty goal. In order to meet this goal, the Commission spearheads innovations to secure early intervention, to establish a statewide system of Children's Centers in the Courts, to improve court proceedings, to promote the healthy development of children in foster care and to focus on the needs of infants involved in child welfare proceedings. All of these endeavors have utilized a systemic methodology of convening stakeholders, conducting research, developing pilot projects, creating written materials and trainings, and initiating policy and practice change. Additionally, these efforts are premised on the court's authority under state and federal law and consistent with the legal standards for services to children. The following summary demonstrates the Commission's inspirations, challenges and achievements.

Commission Accomplishments



↳ **EARLY INTERVENTION:** These efforts began in 1991 when the Commission first studied the process for obtaining services for infants and toddlers with developmental disabilities through the Family Court, and then worked to secure passage of laws establishing a system of early intervention services for New York's children.

These efforts have spurred the passage of federal law requiring that all infants and toddlers in foster care and all children under age three with substantiated cases of abuse and neglect be referred to the Early Intervention Program.

↳ **CHILDREN'S CENTER:** When the Commission was alerted to the needs of children brought to court by caretakers with no child care alternatives, research was conducted to document and understand the caretakers' needs. As a result, a new program – Children's Centers in the Courts – established a network of Centers throughout New York State to provide not only quality child care but also a site to connect children and families with vital services. The Children's Center Literacy Project complements these services by infusing each Center with a reading-rich environment that also gives every child the gift of a new, age-appropriate book.

Today, over 52,000 children are served annually in 32 Centers across the State.

↳ **COURT IMPROVEMENT PROJECT:** Over ten years ago, the Court of Appeals designated the Commission to spearhead a new challenge – implementation of the federal State Court Improvement Project (CIP) to assess and improve foster care proceedings. Following earlier efforts, the Commission convened stakeholder and expert working groups, conducted research assessing the court's handling of proceedings and designed

a plan for reform. The reform plan included two pilot projects in Erie and New York Counties and efforts to develop resources to assist Family Courts statewide. Today, the learning from those pilots have been refined and replicated in best practice courts throughout the State. To help actualize innovation and reform, the Commission created new resources for the court – funding staff to grow local court improvement efforts, increasing the availability and strengthening the ability of New York State Court Appointed Special Advocates, designing a Masters of Social Work judicial internship program to assist judges in identifying and addressing unmet needs and gaps in services, and creating an accessible website containing all of the research, writings and other tools developed by the Commission.

The 2005 New York State Permanency Law further captures the Commission's CIP and well-being reforms by requiring expedited procedures and continuing jurisdiction of cases, permitting case conferencing and mandating permanency hearing reports that contain information on a child's health, early intervention referral and services and education.

↳ **CHILD WELL-BEING:** The Commission initiated three statewide well-being projects to focus the attention of the court and child welfare systems on the healthy development of children in foster care. These projects are premised on the underlying belief that children's well-being must be addressed to improve their prospects of growing up in a permanent family. The Healthy Development Initiative, Babies Can't Wait Project and the Education Project provide checklists, written materials and trainings to help all those involved in child welfare proceedings enhance the well-being of foster children and understand its link to permanency.

These tools are now used throughout the country and have helped shape child welfare policy and practice in New York and nationwide.





Taking advantage of the compilation of research conducted by the Children's Bureau's Office on Child Abuse and Neglect (OCAN) and Caliber Associates and published by the U.S. Department of Health and Human Services, this section is an excerpt from the *Emerging Practices in the Prevention of Child Abuse and Neglect* (Thomas et al., 2003). (See Table 1 for a summary of risk and protective factors.)

Risk Factors

While there are varying schools of thought on the origins of maltreatment, most theories of child maltreatment recognize that the root causes can be organized into a framework of four principal systems: (1) the child, (2) the family, (3) the community, and (4) the society.

- ↳ **CHILD:** Though children are not responsible for the abuse inflicted upon them, certain child characteristics have been found to increase the risk or potential for maltreatment. Children with disabilities or mental retardation, for example, are significantly more likely to be abused (Crosse, Kaye & Ratnofsky, 1993; Schilling & Schinke, 1984). Evidence also suggests that age and gender are predictive of maltreatment risk. Younger children are more likely to be neglected, while the risk for sexual abuse increases with age (Mraovick & Wilson, 1999). Female children and adolescents are significantly more likely than males to suffer sexual abuse.
- ↳ **FAMILY:** Important characteristics of the family are linked with child maltreatment. Families in which there is substance abuse are more likely to experience abuse or are at a higher risk of abuse (Ammerman et al., 1999; Besinger et al., 1999; U.S. Department of Health and Human Services, 1993). But, identifying families in which substance abuse is present can be difficult. The Child Welfare League of America (2001) recently found that substance abuse is present in 40 to 80 percent of families in which children are abuse victims. Recent studies also have established a link between having a history of childhood abuse and becoming a victimizer later in life, including Clarke et al. (1999), confirming some of the earliest work in the field. DiLillo, Tremblay, and Peterson (2000) found that childhood sexual abuse increased the risk of perpetrating physical abuse on children as adults. Domestic violence and lack of parenting or communication skills also increase the risks of maltreatment to children.
- ↳ **COMMUNITY:** Factors related to the community and the larger society also are linked with child maltreatment. Poverty, for example, has been linked with maltreatment, particularly neglect, in each of the national incidence studies (Sedlak & Broadhurst, 1996), and has been associated with child neglect by Black (2000) and found to be a strong predictor of substantiated child maltreatment by Lee and Goerge (1999). Bishop and Leadbeater (1999) found that abusive mothers reported fewer friends in their social support



networks, less contact with friends, and lower ratings of quality support received from friends. Violence and unemployment are other community-level variables that have been found to be associated with child maltreatment.

- ↳ **SOCIETY:** Perhaps the least understood and studied level of child maltreatment is that of societal factors. Ecological theories postulate that factors such as the narrow legal definitions of child maltreatment, the social acceptance of violence (as evidenced by video games, television and films, and music lyrics), and political or religious views that value noninterference in families above all may be associated with child maltreatment (Tzeng, Jackson, & Karlson, 1991).

Protective Factors

Researchers, practitioners, and policy makers are now increasingly thinking about protective factors within children and families that can reduce risks, build family capacity, and foster resilience. In 1987, case studies of three victims of child maltreatment began to shed light on the dynamics of survival in high-risk settings.

- ↳ **CHILD:** Resilience in maltreated children was found to be related to personal characteristics that included a child's ability to: recognize danger and adapt, distance oneself from intense feelings, create relationships that are crucial for support, and project oneself into a time and place in the future in which the perpetrator is no longer present (Mrazek & Mrazek, 1987).

Since then, researchers have continued to explore why certain children with risk factors become victims and other children with the same factors do not. What are the factors that appear to protect children from the risks of maltreatment? In a recent overview by the Family Support Network, factors that may protect children from maltreatment include child factors, parent and family factors, social and environmental factors. Child factors that may protect children include good health, an above-average intelligence, hobbies or interests, good peer relationships, an easy temperament, a positive disposition, an active coping style, positive self-esteem, good social skills, an internal locus of control, and a balance between seeking help and autonomy.

- ↳ **FAMILY:** Parent and family protective factors that may protect children include secure attachment with children, parental reconciliation with their own childhood history of abuse, supportive family environment including those with two-parent households, household rules and monitoring of the child, extended family support, stable relationship with parents, family expectations of pro-social behavior, and high parental education. Some recent studies have found that families with two married parents encounter more stable home environments, fewer years in poverty, and diminished material hardship (Lerman, 2002).
- ↳ **SOCIETY:** Social and environmental risk factors that may protect children include middle to high socioeconomic status, access to health care and social services, consistent parental employment, adequate housing, family participation in a religious faith, good schools, and supportive adults outside the family who serve as role models or mentors (Family Support Network, 2002).

Risk and Protective Factors for Child Abuse and Neglect



Table 1. Risk and Protective Factors for Child Abuse and Neglect

	Risk Factors*	Protective Factors*
Child Factors	<ul style="list-style-type: none"> • Premature birth, birth anomalies, low birth weight, exposure to toxins in utero • Temperament: difficult/slow to warm up • Physical/cognitive/emotional disability, chronic or serious illness • Childhood trauma • Anti-social peer group • Age • Child aggression, behavior problems, attention deficits 	<ul style="list-style-type: none"> • Good health, history of adequate development • Above-average intelligence • Hobbies and interests • Good peer relationships • Personality factors • Easy temperament • Positive disposition • Active coping style • Positive self-esteem • Good social skills • Internal locus of control • Balance between help seeking and autonomy
Parental/ Family Factors	<ul style="list-style-type: none"> • Personality Factors • External locus of control • Poor impulse control • Depression/anxiety • Low tolerance for frustration • Feelings of insecurity • Lack of trust • Insecure attachment with own parents • Childhood history of abuse • High parental conflict, domestic violence • Family structure – single parent with lack of support, high number of children in household • Social isolation, lack of support • Parental psychopathology • Substance abuse • Separation/divorce, especially high conflict divorce • Age • High general stress level • Poor parent-child interaction, negative attitudes and attributions about child's behavior • Inaccurate knowledge and expectations about child development 	<ul style="list-style-type: none"> • Secure attachment; positive and warm parent-child relationship • Supportive family environment • Household rules/structure; parental monitoring of child • Extended family support and involvement, including caregiving help • Stable relationship with parents • Parents have a model of competence and good coping skills • Family expectations of pro-social behavior • High parental education
Social/ Environmental Factors	<ul style="list-style-type: none"> • Low socioeconomic status • Stressful life events • Lack of access to medical care, health insurance, adequate child care, and social services • Parental unemployment; homelessness • Social isolation/lack of social support • Exposure to racism/discrimination • Poor schools • Exposure to environmental toxins • Dangerous/violent neighborhood • Community violence 	<ul style="list-style-type: none"> • Mid to high socioeconomic status • Access to health care and social services • Consistent parental employment • Adequate housing • Family religious faith participation • Good schools • Supportive adults outside of family who serve as role models/mentors to child

*This is not an all-inclusive or exhaustive list. These factors do not imply causality and should not be interpreted as such.

Source: Child Welfare Information Gateway, 2004



Taking advantage of the compilation of research presented by the Child Welfare Information Gateway, this section is an excerpt from the publication *Long-term Consequences of Child Abuse and Neglect* (Child Welfare Information Gateway, 2006).

The impact of child abuse and neglect is often discussed in terms of physical, psychological, behavioral, and societal consequences. In reality, however, it is impossible to separate them completely. Physical consequences, such as damage to a child's growing brain, can have psychological implications, such as cognitive delays or emotional difficulties. Psychological problems often manifest as high-risk behaviors. Depression and anxiety, for example, may make a person more likely to smoke, abuse alcohol or illicit drugs, or overeat. High-risk behaviors, in turn, can lead to long-term physical health problems such as sexually transmitted diseases, cancer, and obesity.

The effects vary depending on the circumstances of the abuse or neglect, personal characteristics of the child, and the child's environment. Consequences may be mild or severe; disappear after a short period or last a lifetime; and affect the child physically, psychologically, behaviorally, or in some combination of all three ways. Ultimately, due to related costs to public entities such as the health care, human services, and educational systems, abuse and neglect impact not just the child and family, but society as a whole.

This piece examines the long-term consequences of child abuse and neglect by the following categories:

- ↳ Psychological Consequences
- ↳ Behavioral Consequences
- ↳ Physical Consequences
- ↳ Societal Consequences



Psychological Consequences

The immediate emotional effects of abuse and neglect— isolation, fear, and an inability to trust— can translate into lifelong consequences, including low self-esteem, depression, and relationship difficulties. Researchers have identified links between child abuse and neglect and the following:

- ↳ **POOR MENTAL AND EMOTIONAL HEALTH:** In one long-term study, as many as 80 percent of young adults who had been abused met the diagnostic criteria for at least one psychiatric disorder at age 21. These young adults exhibited many problems, including depression, anxiety, eating disorders, and suicide attempts (Silverman, Reinherz, & Giaconia, 1996). Other psychological and emotional conditions associated with abuse and neglect include panic disorder, dissociative disorders, attention deficit hyperactivity disorder, posttraumatic stress disorder, and reactive attachment disorder (Teicher, 2000).
- ↳ **COGNITIVE DIFFICULTIES:** The National Survey of Child and Adolescent Well-Being found that children placed in out-of-home care due to abuse or neglect tended to score lower than the general population on measures of cognitive capacity, language development, and academic achievement (U.S. Department of Health and Human Services, 2003).
- ↳ **SOCIAL DIFFICULTIES:** Children who are abused and neglected by caretakers often do not form secure attachments to them. These early attachment difficulties can lead to later difficulties in relationships with other adults as well as with peers (Morrison, Frank, Holland, & Kates, 1999).



Behavioral Consequences

Not all victims of child abuse and neglect will experience behavioral consequences; however, child abuse and neglect appear to make the following more likely:

- ↳ **DIFFICULTIES DURING ADOLESCENCE:** Studies have found abused and neglected children to be at least 25 percent more likely to experience problems such as delinquency, teen pregnancy, low academic achievement, drug use, and mental health problems (Kelley, Thornberry, & Smith, 1997).
- ↳ **JUVENILE DELINQUENCY AND ADULT CRIMINALITY:** A National Institute of Justice study indicated being abused or neglected as a child increased the likelihood of arrest as a juvenile by 59 percent. Abuse and neglect increased the likelihood of adult criminal behavior by 28 percent and violent crime by 30 percent (Widom & Maxfield, 2001).
- ↳ **ALCOHOL AND OTHER DRUG ABUSE:** Research consistently reflects an increased likelihood that abused and neglected children will smoke cigarettes, abuse alcohol, or take illicit drugs. According to a report from the National Institute on Drug Abuse, as many as two-thirds of people in drug treatment programs reported being abused as children (Swan, 1998).
- ↳ **ABUSIVE BEHAVIOR:** Abusive parents often have experienced abuse during their own childhoods. It is estimated approximately one-third of abused and neglected children will eventually victimize their own children (Prevent Child Abuse New York, 2003).



Physical Consequences

The immediate physical effects of abuse or neglect can be relatively minor (bruises or cuts) or severe (broken bones, hemorrhage, or even death). In some cases the physical effects are temporary; however, the pain and suffering they cause a child should not be discounted. Meanwhile, the long-term impact of child abuse and neglect on physical health is just beginning to be explored. Below are some outcomes researchers have identified:

- ↳ **SHAKEN BABY SYNDROME:** The immediate effects of shaking a baby, which is a common form of child abuse in infants, can include vomiting, concussion, respiratory distress, seizures, and death. Long-term consequences can include blindness, learning disabilities, mental retardation, cerebral palsy, or paralysis (Conway, 1998).
- ↳ **IMPAIRED BRAIN DEVELOPMENT:** Child abuse and neglect have been shown, in some cases, to cause important regions of the brain to fail to form properly, resulting in impaired physical, mental, and emotional development (Perry, 2002; Shore, 1997). In other cases, the stress of chronic abuse causes a “hyperarousal” response by certain areas of the brain, which may result in hyperactivity, sleep disturbances, and anxiety, as well as increased vulnerability to post-traumatic stress disorder, attention deficit hyperactivity disorder, conduct disorder, and learning and memory difficulties (Dallam, 2001; Perry, 2001).
- ↳ **POOR PHYSICAL HEALTH:** A study of 700 children who had been in foster care for 1 year found that more than one-quarter of the children had some kind of recurring physical or mental health problem (U.S. Department of Health and Human Services, 2003). A study of 9,500 HMO participants showed a relationship between various forms of household dysfunction (including childhood abuse) and long-term health problems such as sexually transmitted diseases, heart disease, cancer, chronic lung disease, skeletal fractures, and liver disease (Felitti et al., 1998; Hillis, Anda, Felitti, Nordenberg, & Marchbanks, 2000).



Societal Consequences

While child abuse and neglect almost always occur within the family, the impact does not end there. Society as a whole pays a price for child abuse and neglect, in terms of both direct and indirect costs.

- ↳ **DIRECT:** Direct costs include those associated with maintaining a child welfare system to investigate allegations of child abuse and neglect, as well as expenditures by the judicial, law enforcement, health, and mental health systems to respond to and treat abused children and their families. A 2001 report by Prevent Child Abuse America estimates these costs at \$24 billion per year.
- ↳ **INDIRECT COSTS:** Indirect costs represent the long-term economic consequences of child abuse and neglect. These include juvenile and adult criminal activity, mental illness, substance abuse, and domestic violence. They can also include loss of productivity due to unemployment and underemployment, the cost of special education services, and increased use of the health care system. Prevent Child Abuse America recently estimated these costs at more than \$69 billion per year (2001).

As noted by the Child Welfare Information Gateway, researchers also have begun to explore why, given similar conditions, some children experience long-term consequences of abuse and neglect while others emerge relatively unscathed. The ability to cope, and even thrive, following a negative experience is sometimes referred to as “resilience.” A number of protective factors may contribute to an abused or neglected child’s resilience. These include individual characteristics, such as optimism, self-esteem, intelligence, creativity, humor, and independence. Protective factors can also include the family or social environment, such as a child’s access to social support; in particular, a caring adult in the child’s life can be an important protective factor. Community well-being, including neighborhood stability and access to health care, is also a protective factor (Thomlison, 1997).



Taking advantage of the compilation of research conducted by the Commission and published by the National Center for Children in Poverty, this section is mostly an excerpt from the *Improving the Odds for the Healthy Development of Young Children in Foster Care* (Dicker, Gordon & Knitzer, 2001) but also relies on other research to widen the scope for older children and youth in foster care. (See Table 2 for a sample of reasons to promote the well-being of children and youth in foster care.)

Young children in foster care are among the most vulnerable children in the country. Nearly 40 percent of them are born low birthweight and/or premature, two factors which increase the likelihood of medical problems and developmental delay (Halfon, Mendonca & Berkowitz, 1995; Silver, Amster & Haecker, 1999). These infants and toddlers are involved in over one-third of all substantiated neglect reports and more than half of all substantiated medical neglect reports (Wulczyn & Hislop, 2000). More than half suffer from serious physical health problems, including chronic health conditions, elevated lead blood-levels, and diseases such as asthma (Blatt, Saletsky, & Meguid, 1997; Chernoff et al., 1994; Halfon, Mendonca & Berkowitz, 1995; Hochstadt et al., 1987; Silver et al., 1999; Takayama, Bergman & Connell, 1994). Dental problems are widespread: one-third to one-half of young children in foster care are reported to have dental decay (Chernoff et al., 1994; Swire & Kavalier, 1997; U.S. General Accounting Office, 2000).

↳ **CHILD DEVELOPMENT:** Over half of young children in foster care experience developmental delays, which is four to five times the rate found among children in the general population (Silver et al., 1999; Silver, Amster & Haecker, 1999; Silver, 2000). For example, one recent study found that more than half of over 200 children in foster care under the age of 31 months had language delays, compared to the general population of preschoolers in which only 2 to 3 percent experience language disorders and 10 to 12 percent have speech disorders (Amster, Greis & Silver, 1997). The risks to healthy development are especially pronounced for infants. Infants comprise the largest cohort of the young child foster care population, accounting for one in five admissions to foster care and remaining in care longer than older children. Infants placed within three months of birth are those most likely to enter care and spend the longest time in care – twice as long as older children. One-third of all infants discharged from foster care reenter the child welfare system, further undermining the likelihood of their healthy development (Wulczyn & Hislop, 2000). In the recent past, most of these young children – nearly 80 percent – have been at risk for a wide range of medical and developmental health problems related to prenatal exposure to maternal substance abuse (Goerge & Wulczyn, 1998/1999; U.S. General Accounting Office, 1994).

↳ **EMOTIONAL AND BEHAVIORAL DEVELOPMENT:** All young children in foster care also face heightened risk of emotional and behavioral problems. The inconsistent and unresponsive caregiving to which they are often exposed sets the stage for potentially serious emotional and behavioral difficulties, often involving difficulty in forming close relationships and managing emotions (Katz, 1987; Morrison et al., 1999). As infants and toddlers, the children may show signs of attachment disorders. As preschoolers, their behavior may be especially

Children in Foster Care



challenging and provocative, or they may show signs of anxiety and depression. These problems not only affect the children, but often cause great stress for those who care for them: relatives, foster parents, and child care providers, as well as their biological parents. If severe enough, these issues can disrupt the placement of the children in foster homes and prevent successful permanency outcomes. But despite their vulnerability, too many young children in foster care do not receive services that can address and ameliorate these risks. A significant percentage does not even receive basic health care, such as immunizations, dental services, hearing and vision screening, and testing for exposure to lead and communicable diseases. Specialized needs such as developmental delays and emotional and behavioral conditions are even less likely to be addressed (Knitzer, 2000; Rosenfeld, 1997).

↳ **SECURITY OR PERMANENCY:** Children of all ages need to feel secure, and permanency provides the foundation and bonds that contribute to a person's well-being throughout his or her lifetime. The emotional, physical, social and economic bonds from childhood provide an ever-important magnitude of supports. Imagine going through childhood without anyone to laugh and cry with or to share the thrills of major and minor successes or the annoyances of everyday experiences throughout the life course. Imagine not having any person to reference as a contact in case of an emergency.

Data indicate the numbers of children in foster care are decreasing and that permanency outcomes for children in foster care are becoming more prevalent. As noted by Barbell and Freundlich (2001), foster parents take on a number of traditional roles, including: nurturing, supporting the children's healthy development and providing guidance and discipline. As the system moves toward a new model of permanency and recognizes the strengths that foster parents bring to their role in a child's life, that role has been expanded to include advocating on behalf of the children with schools; mentoring birth parents; supporting the relationship between children and birth parents; and recruiting, training, and mentoring new foster parents (Child Welfare League of America, 1995; Dougherty, 2001). In addition, a growing number of foster parents are adopting the children they have fostered (Barbell & Freundlich, 2001).

Still many children and youth remain in foster care for years and a substantial number remain in foster care until they are emancipated (aged out). Living in long-term foster care has been found to have a primarily negative impact on the central process of adolescent identity development. Adolescent perceptions of the contextual features of foster care and the experiences encountered while in foster care led to the identification of two major, parallel processes: the devaluation of self by others and the protection of the self (Kools, 1997). Youth who are emancipated from foster care without a permanent family have been found to be at high risk for many poor outcomes. Findings from a longitudinal study of 141 youth aging out of foster care showed one in five (22%) had lived in four or more places within 18 months of discharge from care; more than one-third (37%) had been physically or sexually victimized, incarcerated, or homeless during that time period; and these youth had considerably more mental health challenges than others in the same age group (Courtney et al., 2001). Further, more than one-third (37%) had not completed high school, and only 61 percent were employed after 18 months with meager wages (median wage was \$4.60/hour) (Courtney et al., 2001).



Children in Foster Care



Table 2. Reasons To Promote the Healthy Development of Children in Foster Care

<p>New scientific knowledge shows the importance of the earliest years.</p>	<p>Emerging research makes it very clear that stable, nurturing early relationships are key to a child’s social and emotional development. All children are born wired for feelings and ready to learn, but early experiences and/or exposure to risk factors can disrupt these processes (Shonkoff & Phillips, 2000; Shore, 1997). Indeed, a compelling body of cumulative science indicates that the more risks children experience, the more likely they are to have serious negative consequences that are reflected in their behavior and development. Since research shows that children in foster care experience many risk factors, this is a very troubling picture (Thorpe & Swart, 1992; Werner & Smith, 1992). However, research also suggests that intensive and early interventions can help reduce the harm that young children in foster care face due to their experiences with multiple risk factors (Gross, Spiker, & Haynes, 1997; Zeanah & Larrieu, 1998).</p>
<p>Children in foster care are the state’s children.</p>	<p>All children in foster care are placed by court order in the custody of the state. The court order vests the state with powers typically exercised by parents for all other children. The state determines where and with whom a child will live, the nature of any medical care, and whether the child receives early childhood services or other services to address his or her needs. Neither the biological parent nor a foster parent who may know the child best has authority to make all vital decisions on a child’s behalf. Thus, unlike most other young children, many children in foster care often lack the most fundamental resource to ensure their healthy development—a stable relationship with an adult who can observe their development over time, advocate on their behalf, and provide consent to services. Because of these enormous powers, the state has an enhanced responsibility to children in foster care above and beyond its responsibility to all other children—it has a responsibility to improve their well-being and to strengthen their families. Consistent with that enhanced responsibility, federal and state law mandates that state child welfare policy and practice ensure a child’s safety and wellbeing and promote permanence. (The Omnibus Budget Reconciliation Act of 1989 requires states to maintain up-to-date health records, such as immunization records and a child’s health conditions, for children in foster care.) Ignoring their needs and failing to provide parents and foster parents with support compromises the well-being of these children and can undermine the child welfare system’s family-building efforts. One way to meet these obligations is for states to ensure that young children receive appropriate and timely services, their caregivers receive respite and support, and caseworkers and court personnel understand the connections between reducing the developmental risks to young children in foster care and achieving permanency. For example, ensuring reunification, adoption, or a stable foster or kinship care placement for a young child with severe disabilities, chronic health problems, or emotionally challenging behavior is likely to be much easier if the caregivers receive respite care as well as training to manage their child’s special needs.</p>
<p>It is in society’s economic and social interest to promote positive outcomes for young children in foster care.</p>	<p>The third reason to promote strategic attention to interventions targeted to young children in foster care is that this nation has a vested interest in promoting the healthy development of all of its young children. In fact, more and more states are crafting policies to promote sound developmental and family support services for their young children (Cauthen, Knitzer, & Ripple, 2000). Congress, too, has weighed in. Recognizing the links among early development, school readiness, and later school performance, this nation has set forth a national goal that “all children shall enter school ready to learn” (Goals 2000: Educate America Act, 1994). All children, of course, includes young children in foster care. But given the level of risk so many children in foster care face, promoting their healthy development and school readiness requires more than business as usual. Indeed, failing to address these young children’s needs has costly consequences for society. Children who have spent part of their childhood in foster care are more likely than other children to suffer adverse outcomes such as dropping out of school, teen pregnancy, homelessness, or incarceration (Courtney & Piliavan, 1999).</p>

Source: Dicker, Gordon & Knitzer, 2001

Conclusion



Child abuse and neglect occurs in families across all socioeconomic, religious, and racial and ethnic groups. There is no single, identifiable cause of child maltreatment. Instead, abuse and neglect tend to occur as a result of an interaction of multiple forces that impact the family. The presence of known risk factors does not necessarily lead to family violence, and factors that may cause violence in one family may not result in violence in another family (DePanfilis & Salus, 1992). There are short- and long-term negative consequences related to child abuse and neglect, including adverse health, educational attainment and social and behavioral development.

Children are placed into foster care for a wide variety of reasons, including: safety issues, their families are at least temporarily unable to care for them, specialized care or treatment is needed, or behavioral problems have led to a placement. Since children in foster care make up a majority of those in out-of-home care in New York State, this measure also provides insight into the extent to which children are removed from their homes and placed in out-of-home care in New York State.

To minimize the trauma of placement to children, the court seeks to place children in a foster care setting that is least disruptive and most family-like, consistent with a child's needs. Decisions are based on "the best interests of the child." The court then assumes the responsibility of continuing oversight until a permanent home is found. The court is charged with directing CPS to implement a service plan that identifies problems to be resolved, changes in parental behavior to be achieved, services to be provided to the family, special needs of the child and services to meet these needs, visitation, and deadlines for achieving plan goals. Regardless of the type of placement a child is in, placement in foster care presents children with change and loss, e.g., loss of parents, siblings, school, friends and community. Many children face multiple placements, which call upon children to enter and leave multiple relationships at a time in their development when consistency and stability are paramount.

Ensuring the well-being of children in or at risk of foster care is an investment in the future that can help achieve the goals this society wants for all its children – that they are safe, that they grow up in a loving home, and that they develop to their full potential. Improving outcomes for children and youth in foster care is a doable task. Judicial leadership; the creative use of federal and state programs; new approaches to ensuring access to age-appropriate health, developmental, and mental health services for children and youth in foster care; and linking all of these elements to the network of early childhood, youth development and family support programs within a community are important building blocks to help ensure the needs of children and youth in or at risk of foster care placement are being met. The broad, child-focused data presented in *The CHILD in Child Welfare and the Courts* aims to inform policy development, planning and accountability as a means to improve outcomes for children and youth involved with child welfare and the courts.

References



Ammerman, R., D. Kolko, L. Kirisci, T. Blackson and M. Dawes. 1999. Child abuse potential in parents with histories of substance abuse disorder. *Child Abuse and Neglect* 23: 1225-1238.

Amster, B., S. M. Greis and J. Silver. 1997. Feeding and language disorders in young children in foster care. Paper presented at the American Speech Language Hearing Association Annual Convention, November 22, Boston, MA.

Barbell, Kathy and Madelyn Freundlich. 2001. *Foster care today*. Washington, DC: Casey Family Programs. http://www.casey.org/NR/rdonlyres/89981DE1-D4B8-4136-82DD-DD1C8FDEF7CE/129/casey_foster_care_today.pdf

Besinger, B., A. Garland, A. Litrownik, and J. Landsverk. 1999. Caregiver substance abuse among maltreated children placed in out-of-home care. *Child Welfare* 78(2): 221-239.

Bishop, S. and B. Leadbeater. 1999. Maternal social support patterns and child maltreatment: Comparison of maltreating and nonmaltreating mothers. *American Journal of Orthopsychiatry* 69: 172-181.

Black, D. A., R. E. Heyman and A. M. Smith Slep. 2001. Risk factors for child physical abuse. *Aggression and Violent Behavior* 6: 121-188.

Black, M. 2000. The roots of child neglect. In: R.M. Reece (Ed.) *Treatment of child abuse: Common mental health, medical, and legal practitioners*. Baltimore, MD: Johns Hopkins University Press.

Blatt, S. D., R. D. Saletsky, and V. Meguid, 1997. A comprehensive, multidisciplinary approach to providing health care for children in out-of-home care. *Child Welfare* 76(2): 331-349.

Cauthen, N. K., J. Knitzer and C. Ripple. 2000. *Map and track: State initiatives for young children and families*. New York, NY: National Center for Children in Poverty, Mailman School of Public Health, Columbia University.

Chalk, R., A. Gibbons, and H. J. Scarupa. 2002. *The multiple dimensions of child abuse and neglect: New insights into an old problem*. Washington, DC: Child Trends. Accessed April 27, 2006, from www.childtrends.org/Files/ChildAbuseRB.pdf.

Chalk, R. and R. A. King. 1998. *Violence in families: Assessing prevention and treatment programs*. Pp.41-50. Washington, DC: National Academy Press.

Chernoff, M. D., T. Combs-Orme, C. Risley-Curtiss, and A. Heisler. 1994. Assessing the health status of children entering foster care. *Pediatrics* 93(4): 594-601.

Child Welfare Information Gateway. 2004. *Risk and protective factors for child abuse and neglect*. Washington, DC: U.S. Department of Health and Human Services. Available online <http://www.childwelfare.gov/preventing/programs/whatworks/riskprotectivefactors.pdf>.

Child Welfare Information Gateway. 2006. *Long-term consequences of child abuse and neglect*. Washington, DC: U.S. Department of Health and Human Services. Available online http://www.childwelfare.gov/pubs/factsheets/long_term_consequences.pdf.

Child Welfare League of America. 1995. *CWLA standards of excellence for family foster care*. Washington, DC: CWLA.

References



Child Welfare League of America. 2001. *Alcohol, other drugs, and child welfare*. 2001/0-87868-839-0/#8390. Washington, DC: CWLA.

Clarke, J., M. Stein, M. Sobota, M. Marisi and L. Hanna. 1999. Victims as victimizers: Physical aggression by persons with a history of childhood abuse. *Archives of Internal Medicine* 159: 1920-1924.

Conway, E. E. 1998. Nonaccidental head injury in infants: The shaken baby syndrome revisited. *Pediatric Annals*, 27(10): 677-690.

Courtney, M. E. and I. Piliavan. 1999. *Foster care transitions to adulthood: Outcomes 12 to 18 months after leaving care*. Madison, WI: University of Wisconsin-Madison School of Social Work and Institute for Research on Poverty.

Courtney, M. E., I. Piliavin, A. Grogan-Kaylor, & A. Nesmith. 2001. Foster youth transitions to adulthood: A longitudinal view of youth leaving care. *Child Welfare*, 80(6): 685-717.

Crosse, S., E. Kaye, and A. Ratnofsky. 1993. *A report on the maltreatment of children with disabilities*. Washington, DC: National Clearinghouse on Child Abuse and Neglect Information.

Dallam, S. J. (2001). The long-term medical consequences of childhood maltreatment. In: K. Franey, R. Geffner, & R. Falconer (Eds.). *The cost of child maltreatment: Who pays? We all do*. San Diego, CA: Family Violence & Sexual Assault Institute.

Davies, D. 1999. *Child Development: A Practitioner's Guide*. New York, NY: Guilford Press.

Dicker, S., E. Gordon and J. Knitzer. 2001. *Improving the odds for the healthy development of young children in foster care*. Promoting the Emotional Well-Being of Children and Families Policy Paper no. 2. New York, NY: National Center for Children in Poverty.

DiLillo, D., G. Tremblay and L. Peterson. 2000. Maternal anger. *Child Abuse and Neglect* 24(6): 767-779.

Dougherty, S. 2001. *Toolbox no. 2: Expanding the role of foster parents in achieving permanency*. Washington, DC: Child Welfare League of America.

Family Support Network. 2002. *Child abuse and neglect*. Available: <http://www.childwelfare.gov/>.

Felitti, V. J., R. F. Anda, D. Nordenberg D. F. Williamson, A. M. Spitz, Edwards, V., M.P. Koss and J.S. Marks. 1998. Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The adverse childhood experiences (ACE) study. *American Journal of Preventive Medicine* 14(4): 245-258.

Goals 2000: Educate America Act, P.L. 103-227, enacted March, 1994. Available online <http://www.ed.gov/legislation/GOALS2000/TheAct/index.html>.

Gross, R. T., D. Spiker and C. W. Haynes (Eds.). 1997. *Helping low birth weight, premature babies: The Infant and Health Development Program*. Stanford, CA: Stanford University Press.

Halfon, N., A. Mendonca and G. Berkowitz, 1995. *Health status of children in foster care: The experience of the Center for the Vulnerable Child*. *Archives of Pediatric and Adolescent Medicine* 149(4): 386-392.

References



- Harrington, D. and H. Dubowitz. 1999. Preventing child maltreatment. In R. L. Hampton (Ed.), *Family violence: 2nd edition. Prevention and treatment*. Thousand Oaks, CA: Sage Publications.
- Heyman, R. E. and A. M. Smith Slep. 2001. Risk factors for family violence: Introduction to the special series. *Aggression and Violent Behavior* 6: 115-119.
- Hillis, S. D., R. F., Anda, V. J., Felitti, D., Nordenberg and P.A. Marchbanks. 2000. Adverse childhood experiences and sexually transmitted diseases in men and women: A retrospective study. *Pediatrics*, 106(1): 1-6.
- Hochstadt, N., P. Jaudes, D. Zimo, and J. Schachter. 1987. The medical and psychosocial needs of children entering foster care. *Child Abuse & Neglect* 11(1): 53-62.
- Katz, L. L. 1987. An overview of current clinical issues in separation and placement. *Child and Adolescent Social Work* 4(3-4): 61-77.
- Kelley, B. T., T. P. Thornberry, and C. A. Smith. 1997. *In the wake of childhood maltreatment*. Washington, DC: National Institute of Justice. Accessed April 27, 2006, from <http://www.ncjrs.gov/pdffiles1/165257.pdf>.
- Klee, L., D. Kronstadt and C. Zlotnick. 1997. Foster care's youngest: A preliminary report. *American Journal of Orthopsychiatry* 67(2): 290-299.
- Knitzer, J. 2000. Early childhood mental health services: A policy and systems development perspective. In J. P. Shonkoff and S. J. Meisels. *Handbook of early childhood intervention*. New York, NY: Cambridge University Press.
- Kools, Susan M. 1997. "Adolescent identity development in foster care." *Family Relations* 46: 263-271.
- Lee, B., and R. Goerge. 1999. Poverty, early childbearing, and child maltreatment: A multinomial analysis. *Child and Youth Services Review* 21(9-10): 755-780.
- Lerman, R. 2002. *Wedding bells ring in stability and economic gains for mothers and children*. Urban Institute. Available: <http://www.urban.org/publications/900554.html>.
- Morrison, J. A., S. J. Frank, C. C. Holland and W. R. Kates. 1999. Emotional development and disorders in young children in the child welfare system. In: Silver, J. A., B. J. Amster and T. Haecker (Eds.). *Young children and foster care*. Baltimore, MD: Paul H. Brookes Publishing Co.
- Mraovick, L. and J. Wilson. 1999. Patterns of child abuse and neglect associated with chronological age of children living in a midwestern county. *Child Abuse and Neglect* 23(9): 899-903.
- Mrazek, P. and D. Mrazek. 1987. Resilience in child maltreatment victims: A conceptual exploration. *Child Abuse and Neglect* 11: 357-366.
- National Research Council. 1993. *Understanding child abuse and neglect*. Panel on Research on Child Abuse and Neglect. Washington, DC: National Academy Press.
- Perry, B. D. 2001. The neurodevelopmental impact of violence in childhood. In: D. Schetky & E. Benedek (Eds.), *Textbook of child and adolescent forensic psychiatry* (pp. 221-238). Washington, DC: American Psychiatric Press. Accessed April 27, 2006, from the Child Trauma Academy website: www.childtrauma.org/CTAMATERIALS/Vio_child.asp.

References



- Prevent Child Abuse America. 2001. *Total estimated cost of child abuse and neglect in the United States*. Accessed April 27, 2006, from http://member.preventchildabuse.org/site/DocServer/cost_analysis.pdf?docID=144.
- Prevent Child Abuse New York. 2003. *The costs of child abuse and the urgent need for prevention*. Accessed April 27, 2006, from <http://pca-ny.org/pdf/cancost.pdf>.
- Rosenfeld, A. A. 1997. Foster care: An update. *Journal of the American Academy of Child and Adolescent Psychology*, 36(4): 448-457.
- Schilling, R. and S. Schinke. 1984. Personal coping and social support for parents of handicapped children. *Child and Youth Services Review* 6: 195-206.
- Schumaker, J. A., A. M. Smith Slep and R. E. Heyman. 2001. Risk factors for child neglect. *Aggression and Violent Behavior* 6: 231-254.
- Sedlak, A. and D. Broadhurst. 1996. *Third National Incidence Study of child abuse and neglect: Final report*. Washington, DC: U.S. Government Printing Office.
- Shonkoff, J. and D. Phillips (Eds.). 2000. *From neurons to neighborhoods: The science of early childhood development*. Washington, DC: National Academy Press.
- Shore, R. 1997. *Rethinking the brain: New insights into early development*. New York, NY: Families and Work Institute.
- Silver, J. 2000. Integrating advances in infant research with child welfare policy and practice. *Protecting Children* 16(5): 12-21.
- Silver, J. A., B. J. Amster and T. Haecker (Eds.). 1999. *Young children and foster care*. Baltimore, MD: Paul H. Brookes Publishing Co.
- Silver, J., P. M. DiLorenzo, P. E. Zukoski, Ross, B. J. Amster and D. Schlegel. 1999. Starting young: Improving the health and developmental outcomes of infants and toddlers in the child welfare system. In K. Barbell and L. Wright, (Eds.). Special edition: Family foster care in the next century. *Child Welfare*, 78(1): 148-165.
- Silverman, A. B., H. Z. Reinherz and R.M. Giaconia. 1996. The long-term sequelae of child and adolescent abuse: A longitudinal community study. *Child Abuse and Neglect*, 20(8): 709-723.
- Swan, N. 1998. Exploring the role of child abuse on later drug abuse: Researchers face broad gaps in information. *NIDA Notes*, 13(2). Accessed April 27, 2006, from the National Institute on Drug Abuse website: www.nida.nih.gov/NIDA_Notes/NNVol13N2/exploring.html.
- Swire, M. R. and F. Kavalier. 1997. The health status of foster children. *Child Welfare* 56(10): 635-653.
- Takayama, J. I., A. B. Bergman, and F. A. Connell. 1994. Children in foster care in the state of Washington: Health care utilization and expenditures. *Journal of American Medical Association* 271(23): 1850-1855.
- Teicher, M. D. 2000. Wounds that time won't heal: The neurobiology of child abuse. *Cerebrum: The Dana Forum on brain science*, 2(4): 50-67.

References



Thomas, David, Christine Leicht, Candy Hughes, Amy Madigan and Kathy Dowell. 2003. *Emerging Practices in the Prevention of Child Abuse and Neglect*. U.S. Department of Health and Human Services Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau, Office on Child Abuse and Neglect. Available online <http://www.childwelfare.gov/preventing/programs/whatworks/report/index.cfm>.

Thomlison, B. 1997. Risk and protective factors in child maltreatment. In M. W. Fraser (Ed.), *Risk and resilience in childhood: An ecological perspective*. Washington, DC: NASW Press.

Thorpe, M. and G. T. Swart. 1992. Risk and protective factors affecting children in foster care: A pilot study on the role of siblings. *Canadian Journal of Psychiatry* 37(9): 616.

Tzeng, O., J. Jackson, and H. Karlson. 1991. *Theories of child abuse and neglect: Differential perspectives, summaries, and evaluations*. New York, NY: Praeger Publishers.

U.S. Department of Health and Human Services. 2006. *Child maltreatment 2004*. Washington, DC: Government Printing Office. Accessed April 27, 2006, from <http://www.acf.hhs.gov/programs/cb/pubs/cm04/cm04.pdf>.

U.S. Department of Health and Human Services. 2003. *National Survey of Child and Adolescent Well-Being: One year in foster care wave 1 data analysis report*. Accessed April 27, 2006, from www.acf.hhs.gov/programs/opre/abuse_neglect/nscaw/reports/nscaw_oyfc/oyfc_title.html.

U.S. Department of Health and Human Services. 1993. *Study of child maltreatment in alcohol abusing families*. Washington, DC: National Center on Child Abuse and Neglect.

U.S. General Accounting Office. 1994. *Foster care: Parental drug abuse has an alarming impact on young children* (GAO/HEHS-94-89). Washington DC: U.S. General Accounting Office.

U.S. General Accounting Office. 2000. *Oral health: Dental disease is a chronic problem among low-income populations* (GAO/HEHS-00-72). Washington, DC: U.S. General Accounting Office.

Werner, E. and Smith, R. 1992. *Overcoming the odds: High-risk children from birth to adulthood*. Ithaca, NY: Cornell University Press.

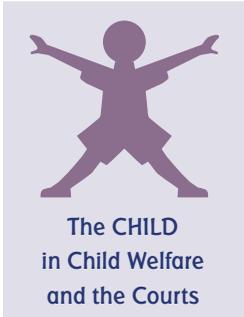
Widom, C. S. and M. G. Maxfield. 2001. An update on the 'cycle of violence.' Washington, DC: National Institute of Justice. Accessed April 27, 2006, from www.ncjrs.gov/pdffiles1/nij/184894.pdf.

Wulczyn, F. and K. B. Hislop. 2000. *The placement of infants in foster care*. Chicago, IL: Chapin Hall Center for Children, University of Chicago.

Zeanah, C. H. and J. A. Larrieu. 1998. Intensive intervention for maltreated infants and toddlers in foster care. *Child and Adolescent Psychiatric Clinics of North America* 7(2): 357-371.

From NYS Touchstones to The CHILD in Child Welfare and the Courts:
A Progression of Data-driven Efforts to Improve Outcomes for Children



Project/Timeline	Background	Purpose
<p>Mid 1990s</p> 	<p>The Council on Children and Families and its member agencies* developed broad, cross-agency goals and objectives for children and families that established the framework for NYS Touchstones. These goals and objectives represent expectations about the future and are organized by six major life areas: economic security, physical and emotional health, education, citizenship, family, and community. Each life area has a set of indicators that reflect the status of children and families. The framework is presented on the following pages.</p>	<p>The New York State Touchstones vision is: <i>All children, youth and families will be healthy and have the knowledge, skills and resources to succeed in a dynamic society.</i></p>
<p>1997</p> 	<p>Soon after Touchstones was developed, the Council became part of the state-level KIDS COUNT network, funded by the Annie E. Casey Foundation. The NYS Touchstones/KIDS COUNT 1998 Data Book was the first publication using the Touchstones framework. The Council continues to produce annual data books as data books play an important role in highlighting the status of children and families and in the data dissemination process.</p>	<p>New York State Touchstones/KIDS COUNT aims to <i>advance the use of children's health, education and well-being indicators as a tool for policy development, planning, and accountability.</i></p>
<p>December 2003</p> 	<p>KWIC is an interactive website that advances the Touchstones/KIDS COUNT data dissemination process by expanding access to New York State children's health, education and well-being data; providing more current data; expanding the number of indicators presented; providing access to other data resources; allowing users to chart, graph and map data; and giving users the ability to tailor data to fit their needs. KWIC, a one-stop data warehouse with data from numerous Council agencies, is available to data users twenty-four hours a day, seven days a week.</p>	<p>KWIC's goal is to <i>promote efforts to gather, plot and monitor children's health, education and well-being indicator data as a means to improve outcomes for New York State's children and families.</i></p>
<p>2006</p>  <p>The CHILD in Child Welfare and the Courts</p>	<p>The Unified Court System's Permanent Judicial Commission on Justice for Children approached the Council and the NYS Office of Children and Family Services (OCFS) to develop a data dissemination mechanism for child welfare and court data that took advantage of the familiarity and usability of the New York State Touchstones/KIDS COUNT format and the data disseminating abilities of KWIC. This project not only brings UCS and OCFS data together but also turns the focus of child welfare data onto the child and away from the process. The Commission administers the federally-funded Court Improvement Project. Funding for The CHILD in Child Welfare and the Courts is made possible by a grant from Fostering Results, a project of the Pew Charitable Trusts.</p>	<p>The CHILD in Child Welfare and the Courts aims to <i>propel data-driven efforts to improve outcomes for children and youth involved with child welfare by focusing on the child and by providing a broader context of well-being for policy development, planning and accountability.</i></p>

* State Office for the Aging • Office of Alcoholism and Substance Abuse Services • Office of Children and Family Services • Division of Criminal Justice Services • State Education Department • Department of Health • Department of Labor • Office of Mental Health • Office of Mental Retardation and Developmental Disabilities • Division of Probation and Correctional Alternatives • Commission on Quality of Care and Advocacy for Persons with Disabilities • Office of Temporary and Disability Assistance

Life Areas, Goals, Objectives and Indicators

Economic Security

Goal 1:

Children and youth will be raised in families with sufficient economic resources to meet their basic needs.

OBJECTIVE 1: Children will be raised in households with sufficient economic resources to provide food, clothing shelter and other necessities.

OBJECTIVE 2: Children and youth will receive adequate financial support from absent parents.

Goal 2:

Youth will be prepared for their eventual economic self-sufficiency.

OBJECTIVE 1: Youth will have skills, attitudes and competencies to enter college, the workforce or other meaningful activities.

OBJECTIVE 2: Young adults who can work will have opportunities for employment.

OBJECTIVE 3: Youth seeking summer jobs will have employment opportunities.

Indicators:

→ Children and Youth Living Below Poverty

Physical and Emotional Health

Goal 3:

Children and youth will have optimal physical and emotional health.

OBJECTIVE 1: Children and youth will be born healthy.

OBJECTIVE 2: Children and youth will be free from preventable disease and injury.

OBJECTIVE 3: Children and youth will have nutritious diets.

OBJECTIVE 4: Children and youth will be physically fit.

OBJECTIVE 5: Children and youth will be emotionally healthy.

OBJECTIVE 6: Children and youth will be free from health risk behaviors (e.g., smoking, drinking, substance abuse, unsafe sexual activity).

OBJECTIVE 7: Children and youth will have access to timely and appropriate preventive and primary health care.

OBJECTIVE 8: Children with special health care needs will experience an optimal quality of life.

OBJECTIVE 9: Children and youth with service needs due to mental illness, developmental disabilities and/or substance abuse problems will have access to timely and appropriate services.

Indicators:

- Adolescent Births and Pregnancies
- Infant, Neonatal and Postneonatal Mortality
- Low Birthweight Births & Premature Births

Education

Goal 4:

Children will leave school prepared to live, learn and work in a community as contributing members of society.

OBJECTIVE 1: Children will come to school ready to learn.

OBJECTIVE 2: Students will meet or exceed high standards for academic performance and demonstrate knowledge and skills required for lifelong learning and self-sufficiency in a dynamic world.

OBJECTIVE 3: Students will be educated in a safe, supportive, drug free and nurturing environment.

OBJECTIVE 4: Students will stay in school until successful completion.

Indicators:

→ Annual Dropouts — Public Schools

Life Areas, Goals, Objectives and Indicators

Citizenship

Goal 5:

Children and youth will demonstrate good citizenship as law-abiding, contributing members of their families, schools and communities.

OBJECTIVE 1: Children and youth will assume personal responsibility for their behavior.

OBJECTIVE 2: Youth will demonstrate ethical behavior and civic values.

OBJECTIVE 3: Children and youth will understand and respect people who are different from themselves.

OBJECTIVE 4: Children and youth will participate in family and community activities.

OBJECTIVE 5: Children and youth will have positive peer interactions.

OBJECTIVE 6: Children and youth will make constructive use of leisure time.

OBJECTIVE 7: Youth will delay becoming parents until adulthood.

OBJECTIVE 8: Children and youth will refrain from violence and other illegal behaviors.

Indicators:

- Adolescent Arrests for Property and Violent Crimes
- Adolescent Arrests for Drug Use/Possession/Sale/DUI
- Assault Hospitalizations
- Driving While Intoxicated Arrests
- Persons in Need of Supervision (PINS) Cases Opened for Services

Family

Goal 6:

Families will provide children with safe, stable and nurturing environments.

OBJECTIVE 1: Parents/caregivers will provide children with a stable family relationship.

OBJECTIVE 2: Parents/caregivers will possess and practice adequate child rearing skills.

OBJECTIVE 3: Parents/caregivers will be literate.

OBJECTIVE 4: Parents/caregivers will be positively involved in their children's learning.

OBJECTIVE 5: Parents/caregivers will have the knowledge and ability to access support services for their children.

OBJECTIVE 6: Parents/caregivers will provide their children with households free from physical and emotional abuse, neglect and domestic violence.

OBJECTIVE 7: Parents/caregivers will provide their children with households free from alcohol and other substance abuse.

Indicators:

- Child Abuse and Maltreatment — Indicated Reports
- Child Abuse and Maltreatment — Children and Youth in Indicated Reports
- Child Abuse and Maltreatment — Resulting in Removal of Child
- Child Abuse and Maltreatment — Resulting in Court Cases
- Foster Care — Children and Youth In Care
- Foster Care — Children and Youth Admitted to Foster Care
- Foster Care—Children and Youth Admitted to Foster Care by Age
- Foster Care — Children and Youth Admitted to Foster Care by Race/Ethnicity
- Foster Care — Children and Youth Admitted to Foster Care by Placement Type
- Foster Care — Children and Youth Discharged from Foster Care
- Foster Care — Children and Youth Discharged from Foster Care by Placement Type
- Foster Care — Terminated Parental Rights
- Foster Care — Parental Rights Surrendered
- Foster Care — Adoption Milestones

Community

Goal 7:

New York State communities will provide children, youth and families with healthy, safe and thriving environments.

Objective 1: Communities will be economically sound.

Objective 2: The environment will be free of pollutants (e.g., air and water quality will meet healthful standards).

Objective 3: Neighborhoods will be crime free.

Objective 4: Adequate housing will be available.

Objective 5: Adequate transportation will be available.

Goal 8:

New York State communities will provide youth and their families with opportunities to help them meet their needs for physical, social, moral and emotional growth.

OBJECTIVE 1: Communities will make available and accessible formal and informal services (e.g., child care, parent training, recreation, youth services, libraries, museums, parks).

OBJECTIVE 2: Adults in the community will provide youth with good role models and opportunities for positive adult interactions.

OBJECTIVE 3: Communities will provide opportunities for youth to make positive contributions to community life and to practice skill development.

Indicators:

- Firearm Related Index Crimes
- Property and Violent Index Crimes Known to the Police
- Unemployment—Resident Civilian



Indicators can help describe changes over time, identify benchmarks and progress in relation to goals, and reflect the status of children and families. Using the Touchstones framework, the CHILD in Child Welfare and the Courts indicators are organized by six major life areas: Economic Security, Physical and Emotional Health, Education, Citizenship, Community, and Family.

Understanding the story behind the indicator – its purpose, definition and significance – contributes to the accurate and effective interpretation of indicators. Data sources are provided for each indicator. **Agency Source** designates the originator of the data. **Data Source** designates the source for the numerator and **Population Source** designates the source for the denominator or population at risk. **Date Compiled** designates the date of compilation and **Notes** provide relevant facts to help interpret the data.