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Placement Into Foster Care and the Interplay of Urbanicity, Child Behavior Problems, and Poverty

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Child welfare involvement is related to involvement with poverty, but the dimensions of that relationship have not been fully explored. Data from the National Survey of Child and Adolescent Well-Being were used to test the relationship between poverty indicators and placement into foster care. Poverty, ages of children, urban or nonurban settings, and the presence of mental health disorders interact to contribute to placement decisions. In urban areas, poverty is strongly associated with involvement with child welfare services, but children's mental health problems are not. In nonurban areas, children's mental health problems are a far greater contributor to child welfare involvement than poverty. Implications for understanding the dual functions of child welfare placements are provided. Child welfare services continue to address the needs of families with children with substantial behavioral problems—yet, federal child welfare policy includes no recognition of this important role.

Keywords: foster care, poverty, child behavior problems

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The relationship between poverty, child abuse, and placement in out-of-home care has long been recognized (Gordon, 1988). However, the role of child welfare services (CWS) as a response to poverty has always been contentious and ever evolving. The view of the proper role of CWS as a response to poverty has evolved from the notorious efforts of Charles Loring Brace to "dispose of our pauper and vagrant children" (Brace, 1859, p. 1) to the 1909 White House Conference on Children (*Conference on Care*, 1909) where informed citizens agreed that poverty is not a sufficient reason for removing children from their parents. The evolution of this view continued in the last decades as Pelton (1989) and Lindsey (1994) mustered a variety of social science data to argue that CWS were never going to be effective or fair unless the policy and program emphasis was placed on addressing poverty rather than providing services. This shift in attitude has influenced policymakers, and many states now have laws in place that prohibit the removal of children from their parents for such poverty-related reasons as homelessness.

Yet there is still concern that families are forced into CWS for reasons of poverty alone. Even among scholars, such as Roberts (2002), who assert that institutionalized racism drives the decision making forces of the child welfare system to a greater extent than the consideration of poverty, the effect of poverty on placement decisions is still recognized as significant: "an overwhelming body of research on the negative effects of poverty on children tells us that the generous public support of child welfare would drastically reduce cases of child abuse and neglect" (p. 268). This conclusion reflects the common wisdom that the elimination of poverty would have a major impact on CWS involvement. Although few would quibble with this general notion of a relationship between poverty and child welfare involvement,[1] there is little illumination of this relationship from available evidence on the current ways that poverty and associated factors affect the placement decisions of the child welfare system. The findings presented below attempt to add nuance to the discussion by clarifying how the contribution of poverty to child placement varies depending on the relationship with several other case characteristics.

Most central to understanding the ways that initiate out-of-home care under CWS supervision—compared to juvenile justice or mental health supervision—is an understanding of the role of CWS as a provider of placement services for children with behavior problems. Wulczyn & Brunner (2001), using administrative data, have described the differences between children entering foster care from rural and urban areas. Rural children who enter foster care are typically older than urban children who do so, and less often of minority race/ethnicity. Although the race/ethnicity differences can be explained by the corresponding differences in rural/urban demographics, little attention has been paid to understanding the age differences between urban and rural children who enter foster care.

One hypothesis is that the use of foster care in rural areas often arises from the lack of specialty mental health services for chil-

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[1] Writing about neglect in rural areas, Polansky and colleagues concluded, "One would have to be recently arrived from Mars not to think that family income affects the likelihood of child neglect" (1981, p. 22).

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dren; in other words, children in rural areas enter foster care due to mental health treatment needs which cannot be met by available in-home service programs. (U.S. Government Accounting Office [GAO], 2003). As children grow older, they become more likely to use all forms of mental health treatment. Therefore, if CWS use is driven, at least in part, by the need for mental health services, CWS use would vary by age. The objective of our investigation is to determine the general extent to which CWS placement decisions for children are mediated more by poverty, the need for mental health services, and the context of an urban or nonurban service setting.

Child Age

Previous investigations of CWS use, especially placement into out-of-home care, typically find marked differences by age. Young children and their families have greater rates of recurrent abuse, higher risk of injury, higher rates of foster care placement, and remain longer in care (Berrick, Needell, Barth, & Jonson-Reid, 1998). Age groups with the highest proportion of entrances into care are infants and middle teenagers—generally peaking around age 15 (see e.g., Wulczyn, Brunner, & Goerge, 1999). Likewise, analyses from National Survey of Child and Adolescent Well-Being (NSCAW; U.S. Department of Health and Human Services [DHHS], in preparation) indicate that the children who are most likely to enter foster care are the very youngest (0-2) and the oldest (11+) groups in the sample, with children between 3 and 6 being the most likely to remain at home following a child maltreatment investigation.

Children's Mental Health Problems and Placement in Out-of-Home Care

Since the 1970s, child welfare scholars have shown that placement decisions are strongly associated with children's mental health status (Bernstein, Snider, & Meezan, 1975). Fanshel (1992) concluded that we would be better served by a two-tiered child welfare system that had permanency planning goals for about three-fourths of the children and would offer treatment as the program goal for the one-quarter of children who are older and have behavior problems. In those years, and in more recent estimates, between one-fifth and one-third of children entering out-of-home care were doing so because of their own behavior problems. James Bell Associates (2004), in their analysis of the cases that were reviewed as part of the first 32 federal Child and Family Service Reviews, concluded that 18% of case openings primarily involved the child's behavior as the basis and that, among children 11 and older, this rose to 50% of all case openings. They determined that at least 16 states explicitly accepted children into child welfare supervised out-of-home care because of children's behavior.

Recently this relationship has received considerable attention, focusing on children whose parents relinquish custody in order to secure child welfare-funded placements and needed treatment (Dewan, 2002). This phenomenon may be significantly greater than has been previously recognized. Evidence from NSCAW indicates that among children aged 4 and older who are involved with the child welfare system, 45% of those living at home and 54% of those placed into out-of-home care have borderline/clinical mental health problems (Burns et al., 2004). This suggests that CWS are frequently provided to families whose children have serious mental health problems.

Less clear is how children's mental health problems are associated with the delivery of out-of-home care. Perhaps these mental health problems are a result of the child maltreatment that is the sine qua non of admission into CWS. The mental health problems of these children could also be associated with exposure to profound poverty. A strong pattern of findings from studies suggests that poverty and economic stress elevate socio-emotional problems in children—and the longer and deeper a child lives in poverty, the greater the threat to child's mental health (McLeod & Shanahan, 1996). Parents under economic stress are (theoretically) more punitive and physically aggressive with their children and less attentive to the needs of their children (Barth & Blythe, 1983); this may also exacerbate the effect of poverty on children's mental health (McLloyd, 1998). Or perhaps mental health problems are a primary contributor to placement into out-of-home care.

This question would seem easy enough to answer by examining existing records to determine the proportion of children who enter CWS for reasons of obtaining mental health services. Yet, given the requirement by courts and auditors that children not become involved with CWS unless there is child maltreatment, this process is not nearly so overt. Bush (1984) documented the use of child welfare case records to justify service plans as did Lipskey's (1983) classic work showing the many ways that front line staff circumvent regulations to obtain the services that families need. So, there is, basically no direct way to measure this phenomenon. Investigations that surveyed a sample of program managers (U.S. GAO, 2003) and families of children with mental illness (Giliberti & Schilzinger, 2000) have found that many children with significant mental health issues are coming to the attention of CWS for reasons that do not include acts of parental maltreatment. The GAO (2003) offered an estimate of 13,000 children who became involved with juvenile justice or child welfare although their primary need was for mental health care and called for additional research to try to improve on this information. This estimate was based on the approximations of key informants and deserves triangulation from studies using other data collection methods.

Caregiver Risks

By law, involvement in CWS depends principally on risks to the safety of children that are caused by maltreatment by parents or family members. For more than 30 years, maltreatment has been the precondition (under Title IV) for the use of federal dollars for repayment of CWS costs to states. The risk to safety of children is generally considered to follow from elevated parental risks that impair parenting. As previously mentioned, poverty and homelessness are such risks, but there are many others including: social isolation, substance abuse, parental mental health problems, children's special needs or disabilities, domestic violence, and parental health problems (Pecora, Whittaker, Maluccio, & Barth, 2000). Although many studies of CWS dynamics have no measures of parental risk factors, a few have at least some measures. The most prominently described risks are substance abuse, active domestic violence, and parental mental illness.

There is no question that substance abuse has long and routinely been implicated in CWS involvement—beginning in the mid-

1800s (Gordon, 1988) and continuing to the present (Marsh, 2003). This relationship may be direct, based on the impact of substance abuse on parenting, but there are also indirect effects of substance abuse on CWS involvement, which may be mediated through poverty. One of the theories of why poor families are more likely to become involved in CWS recognizes that poor families are more likely to be involved in substance abuse and related activities and have greater exposure to parental arrest, detention, or incarceration. These findings have recently found some favor in empirical analyses (Phillips, Burns, Wagner, & Barth, 2004).

Domestic violence is now understood to be another important indicator of risk for substantial harm to a child (McFarlane, Groff, O'Brien, & Watson, 2003), leading some states to include exposure to domestic violence as a reason for CWS involvement. Previous analyses of NSCAW data indicates lifetime (44%) and past year (29%) prevalence rates of domestic violence among the population of children involved with CWS that are far higher than in the general population (Hazen et al., 2004).

Parental mental illness is a long-known contributor to CWS involvement (see e.g., Polansky et al., 1981; Steele & Pollock, 1968) that has been given less attention in recent years than in the early years of addressing child maltreatment. Much evidence has shown the interactive nature of difficulty in fulfilling parenting roles and managing maternal depression (Belsky & Vondra, 1989). Parental mental illness is a logical contributor to CWS involvement. This study considers the previously cited indicators that parenting capacity is substantially impaired and examines the proportion of cases in which these are present.

Methods

The case characteristics contributing to placement into out-of-home care were studied through analysis of data from the NSCAW, a national probability study of children investigated as victims of child abuse and neglect. The cohort was randomly selected from completed child welfare investigations in a randomly selected group of 92 counties. Caregivers, children, and child welfare workers were invited to take part in the survey between October, 1999 and December, 2000. The CWS intake cohort, used for the present analysis, is comprised of 5,504 youth sampled from child welfare investigations/assessments that closed during the sampling period. Further details about the sampling frame are available elsewhere (NSCAW Research Group, 2002). For analyses that include a mental health indicator, such as the Child Behavior Checklist (CBCL), the sample was constrained to children ages 2 and above ($N = 3{,}798$) to correspond to age-related measures of mental health need.

The NSCAW sample design involves a stratified two-stage sample: the primary sampling units (PSUs) being county child welfare agencies, and the secondary sampling units selected from lists of closed investigations or assessments from the sampled agencies. The sample was subdivided into nine strata—one each for eight large states and a ninth stratum for 28 other states. The nine strata are combined to produce national estimates. Sampling within PSUs was stratified by age (infants versus all others), sexual abuse (versus all other types of maltreatment), and receipt of CWS (NSCAW Research Group, 2002). For these analyses, the data were weighted back to a national probability sample and the variance estimates corrected through the use of SUDAAN 9.0.

Analysis weights were constructed in stages corresponding to the stages of the sample design. The probability of selection into the study was the product of two probabilities: the probability of selecting the PSU and the probability of selecting a youth given the youth's county of residence. Weights were further adjusted to account for small deviations from the original plan that occurred during the sampling, as well as for nonresponse. Additional information about the NSCAW sample design and weight derivation is published elsewhere (NSCAW Research Group, 2002).

Caregiver Reported Measures

Caregivers who were caring for the child at the time of the baseline interview were asked about the following child and family characteristics. Typically, caregivers for in-home children were biological mothers. Most (about 90%) of the caregivers for out-of-home care were either kinship caregivers or nonkinship foster caregivers, as opposed to caregivers of children in residential or group care.

Poverty level. Family income and household size were used to compute the poverty level. Data were collected about the biological, kinship, or foster family home. In cases where the child was placed in out-of-home care, the poverty level refers to the home in which the child currently resides. Thus, we have no caregiver reported level of poverty for all cases in the sample and do not know directly, from the caregivers, about their level of poverty at the time of placement. The sole indicator of poverty status for all children in the sample is from the child welfare risk assessment (see discussion below).

Child Behavior Checklist (CBCL). The CBCL was "designed to provide standardized descriptions of behavior rather than diagnostic inferences" (Achenbach, 1991, p. iii). Items are measured using a 3-point scale (0 = *not true*, 1 = *somewhat or sometimes true*, and 2 = *very true or often true*). The *Total Problems* score was used and is normed on a nationally representative sample of children. The NSCAW sample showed excellent internal consistency for 2- to 3-year-olds ($\alpha = .95$) and 4- to 15-year-olds ($\alpha = .96$). The general population normed T score is 50. Children classified as having clinical/borderline problem behaviors had scores above 60.

Child Welfare Worker Reports on Caregiver Characteristics and Risks

Although much data was collected from caregivers, the study did not interview biological parents unless their children remained in their custody. For that reason, case characteristics for families from which children were removed as well as their current service setting, were best described by the completion of a comprehensive checklist of family risks and strengths completed by the child welfare worker, and scored during the interview with the survey field representative.

Types of alleged maltreatment. Child welfare workers identified the types of maltreatment that had been alleged using a modified Maltreatment Classification Scale (Manly, Cicchetti, and Barnett, 1994). Categories included: (1) physical abuse, (2) sexual abuse, (3) neglect: failure to supervise, and (4) neglect: failure to provide. Additional types of maltreatment categories were aggregated into "other." Although multiple types of maltreatment were gathered, in this study we coded each case according to the most serious type of maltreatment.

Types of placement. Children were categorized by child welfare workers as either residing in-home or out-of-home at the time of the interview. Some youth had been in an alternative placement for some interval between the close of the investigation and the interviews of child, parent, and caregiver that yielded the data for this study. On average, interviews occurred 4 months after the close of the investigation.

Family risks. At the time of the CWS investigation, child welfare workers were asked about the presence or recent history of risk factors in caregiver's lives. For this analysis, the following risks were measured with a series of single item questions that most closely matched the content of the caregiver self-report measures: recent domestic violence, substance abuse, and caregiver mental health problems.

Trouble paying for basic needs. An additional item in the risk assessment for the biological caregivers at the time of the child's removal was "Trouble paying for basic necessities." This indicator warrants additional discussion because of its centrality in the later discussion. To examine the

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relationship between poverty and the likelihood of entering out-of-home placement we use an indicator for poverty based upon the child welfare worker's assessment of a caregiver's ability to provide for basic needs. This child welfare worker-reported poverty indicator reliably differentiates between families based on degree of poverty. The families who are described as having difficulty providing for basic necessities, who we will henceforth call "very poor," are by many indications the neediest in our sample. Approximately 70% of caregivers in the subsample who are not able to meet basic needs are below 100% of the poverty line compared with 62% of other "nonpoor" families. Additionally, these very poor families are more likely to be cited for failure to provide or failure to supervise children than other families.

Finally, there is no significant difference found between the two groups of families in racial characteristic, gender of the child, or having a prior report of abuse or neglect. Families unable to meet basic needs are significantly more likely to be receiving assistance through cash support programs (e.g., Temporary Assistance for Needy Families [TANF]/Aid to Families of Dependent Children [AFDC]), food stamps, or housing support. Fewer than 25% of very poor families receive no government support compared to 45% of other/nonpoor families who receive no government support. On average, very poor families receive support from 1.5 government programs, compared to only one such program for other/nonpoor families ($p < .001$). Calling these families "very poor" and labeling the remainder of families as "other/nonpoor," is not meant to belie that many families that do not have trouble paying for basic necessities are nonetheless poor by other conventional measures and might qualify for other governmental poverty programs.

Urban/nonurban. The urbanicity of the PSU was calculated using Census Bureau definitions for the entire county/PSU. Urban was defined as greater than 50% of the population living in an urban area, whereas nonurban was defined as all areas that did not meet this requirement. Of all children in out-of-home care, 83% are sampled from PSUs determined to be urban and 17% are living in nonurban areas.

Results

Table 1 describes the breakdown of the sample of children by age, ethnic/racial group, maltreatment type, and service setting (in-home; closed to services, in-home; opened to services, foster care, kinship foster care, group care) and by whether or not caregivers were identified as having trouble paying for basic necessities. Among all caregivers, only one quarter have trouble paying for basic necessities. However, half of the caregivers of children entering out-of-home care have trouble paying for basic necessities. Among the older children (11+) who enter out-of-

Table 1
Percentage (SE) of Children from Families Having Trouble Paying for Basic Necessities

		Setting						
		In-home			Out-of-home			
Percent (*SE*)	Total	No CWS	CWS	Total In-home	Foster care	Kinship foster care	Group care	Total out-of-home
Age								
0–2	28	15	39	22	62	63	*	62
	(2.3)	(2.6)	(3.8)	(2.3)	(7.7)	(7.6)	()	(5.5)
3–5	24	20	34	24	45	34	*	35
	(3.1)	(4.0)	(4.9)	(3.3)	(1.1)	(1.3)	()	(8.7)
6–10	23	16	35	23	38	64	16	48
	(2.8)	(3.0)	(3.7)	(2.8)	(8.5)	(8.5)	(1.1)	(5.8)
11+	22	16	29	22	49	38	25	37
	(3.3)	(3.7)	(5.1)	(3.3)	(9.9)	(8.8)	(9.1)	(5.8)
Race/ethnicity								
Black	23	13	36	20	50	54	38	48
	(2.4)	(2.6)	(4.2)	(2.5)	(7.3)	(7.0)	(13.5)	(4.0)
White	25	19	33	22	57	51	15	48
	(1.9)	(2.1)	(3.3)	(2.1)	(4.7)	(9.4)	(8.6)	(6.1)
Hispanic	21	15	30	19	28	59	67	41
	(3.6)	(3.7)	(5.3)	(3.6)	(10.2)	(5.8)	(16.4)	(6.8)
Other	25	16	38	22	55	58	27	53
	(5.0)	(6.8)	(8.2)	(5.1)	(11.4)	(18.4)	(12.6)	(8.5)
Maltreatment type								
Physical abuse	17	13	24	16	17	43	20	28
	(2.1)	(2.5)	(4.0)	(2.2)	(6.5)	(10.1)	(12.7)	(6.0)
Sexual abuse	14	10	20	13	32	42	11	31
	(2.9)	(2.5)	(5.1)	(2.9)	(8.9)	(14.6)	(8.2)	(9.5)
Failure to provide	39	10	45	34	67	82	73	74
	(3.9)	(3.1)	(5.1)	(4.2)	(8.0)	(5.4)	(15.9)	(5.4)
Failure to supervise	25	29	40	23	56	37	15	42
	(2.5)	(5.1)	(4.0)	(2.6)	(11.3)	(4.9)	(11.6)	(5.1)
Other	23	12	35	18	60	58	39	57
	(3.3)	(3.4)	(5.9)	(3.4)	(6.5)	(8.6)	(11.6)	(5.2)
Total	24	16	34	21	50	54	24	49
	(1.6)	(1.7)	(2.6)	(1.7)	(4.8)	(4.8)	(7.3)	(3.7)

Source: U.S. Department of Health & Human Services, in press.
Note. CWS = Child Welfare Services.

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home care, 37% of the caregivers are very poor by this definition, whereas this figure is significantly higher at 62% for the caregivers of the 3- to 5-year-old children. Among children entering group care who are 11+, only 25% are categorized as "very poor."

This analysis focuses on children who have received ongoing services, either in-home or out-of-home and were 2 years or older at the point of this involvement with CWS. Of the total sample, 3,779 children had received some type of service from the child welfare agency, at baseline, and also had an indicator of whether or not they came from families that were "having trouble meeting basic needs." For 478 caregivers, this information was identified as "do not know." The analyses conducted below used the weighted data representing the national population of children in this age range entering out-of-home care; the weighted percentages of children who are receiving ongoing CWS and who are receiving in-home services is 68% and for out-of-home care is 32%.

The data show that a family's ability to meet basic needs is associated with several other case characteristics. Very poor families are more likely to have young children; 28% of very poor families have infants as the index child involved with CWS versus only 18% of other/nonpoor families include ($p < .01$). Very poor caregivers are significantly ($p < .05$) more likely to be involved in an active domestic violence situation than other/nonpoor caregivers (24% versus 14%), have a recent history of arrest (30% versus 15%), have a serious mental health problem (34% versus 22%), have intellectual or cognitive impairment (14% versus 7%), or have a physical impairment (10% versus 5%). Moreover, very poor caregivers are twice as likely to be involved with drugs as other/nonpoor caregivers. Poor families were judged by child welfare workers to be somewhat more cooperative with CWS than nonpoor families (90% vs. 79%, $p < .10$). However, there is no difference in the racial distribution of very poor caregivers compared to other/nonpoor caregivers. The study sample also showed that physical and sexual abuse is less likely to be reported ($p < .05$) among very poor families than among other/nonpoor families.

Urbanicity, Mental Health Services, Risk Factors, and Placement in Out-of-Home Care

The interplay between children's mental health, poverty, and clinical mental health problems becomes clear by examining them in a flow table (see Table 2). Among the very poor children in out-of-home care, children who have a borderline/clinical CBCL comprise about the same proportion as those who do not (urban: 17% vs. 19%; nonurban: 5% vs. 2%). Among those children who are categorized as "other/nonpoor," the proportion with a clinical CBCL is dramatically greater than those without (urban: 29% vs. 17% and nonurban: 10% vs. 1%). These findings show that child welfare service placements are clearly functioning to serve children differently depending on poverty status. Among all the nonurban children in out-of-home care, 83% had a borderline/clinical CBCL, compared to 56% of the urban children. Among the nonpoor children, 68% had a borderline/clinical CBCL vs. 51% of very poor children.

When we further examine the family characteristics of these children, we observe that the children in out-of-home placement with borderline/clinical CBCL scores are somewhat older. The parents of these children are less likely to have problems that are typically associated with caregivers who become involved with CWS, including: mental illness, substance abuse, or active domestic violence (see Table 3). We also see that children who have borderline/clinical CBCL scores and live in families in nonurban areas are far more likely to have parents affected by mental illness, regardless of poverty level (72% poor and 57% nonpoor) when compared to children in urban areas (38% poor and 26% nonpoor). Active domestic violence appears to be similar for children regardless of CBCL score, although it is lowest for children in nonpoor families in nonurban areas.

Among the nonurban children, the proportion of recent psychiatric placements is the highest among the nonpoor children (17%), whereas among the urban children it is highest among the poor children (9%). The data showing that 9% of the nonurban and nonpoor children (without a borderline/clinical CBCL score) have prior psychiatric placements, further marks the significant role that nonurban location and poverty play in the use of child welfare for mental health services. Additionally, it should be noted that of these children, 57% of their caregivers were identified as having parental mental illness.

This table also provides information about the proportion of children whose parents were other/nonpoor and had none of the key parental risk factors (including mental illness, substance

Table 2
NSCAW Children in Out-of-Home Care by Urbanicity, Poverty, and Clinical CBCL (%)[a]

Urbanicity and poverty	%	CBCL status	%	Urbanicity and CBCL	%
Urban/very poor[b]	36	Borderline/clinical CBCL	47	UP and CBCL+	17
		Nonborderline/clinical CBCL	53	UP and nonclinical CBCL	19
Urban/other, nonpoor	46	Borderline/clinical CBCL	62	UNP and CBCL+	29
		Nonborderline/clinical CBCL	38	UNP and nonclinical CBCL	17
Nonurban/very poor	7	Borderline/clinical CBCL	66	NUP and CBCL+	5
		Nonborderline/clinical CBCL	34	NUP and nonclinical CBCL	2
Nonurban/other, nonpoor	11	Borderline/clinical CBCL	88	NUNP and CBCL+	10
		Nonborderline/clinical CBCL	12	NUNP and nonclinical CBCL	1
Total	100			Total	100

Note. CBCL = Child Behavior Checklist; CBCL+ = Clinical or Borderline CBCL; UP = urban very poor; NUP = nonurban other, poor; UNP = urban nonpoor; NUNP = nonurban and nonpoor.
[a] Excludes children younger than 2 because they lack CBCLs.
[b] Poor is defined as indication by child welfare worker that family is unable to pay for basic necessities.

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Table 3
Risk Factors Among Children by Urbanicity, Poverty, and Clinical CBCL

Variable	Mean age of child[a]	Parental mental illness	Parent substance abuse (alcohol or drugs)	Parent active domestic violence	No parent MI, SA, or active DV	Child psychiatric placement (since intake)
Urban						
Urban, poor, CBCL+[b]	9.1	45%	50%	27%	30%	9%
Urban, poor	7.6	38%	63%	25%	28%	2%
Urban, nonpoor/other, CBCL+	9.0	24%	22%	18%	49%	5%
Urban, nonpoor/other	8.1	26%	50%	28%	34%	1%
Nonurban						
Nonurban, poor, CBCL+	9.6	34%	53%	36%	24%	6%
Nonurban, poor	8.7	72%	58%	41%	2%	0%
Nonurban, nonpoor/other, CBCL+	9.4	39%	28%	17%	46%	17%
Nonurban, nonpoor/other	10.0	57%	24%	20%	28%	9%
Total	8.7	34%	43%	24%	36%	6%

Note. MI = mental illness; SA = substance abuse; DV = domestic violence; CBCL = Child Behavior Checklist; CBCL+ = Clinical or borderline CBCL.
[a] Excludes children younger than 2 because they lack CBCL scores.
[b] CBCL+ indicates borderline/clinical CBCL score.

abuse, or active domestic violence) by placement type. Overall, about one third (36%) of these parents were not identified as unfit on any of these grounds. The proportions ranged markedly by urban/nonurban and CBCL status, with only 2% of the children who were nonurban and with an inability to pay for basic necessities having a parent without one of these risk factors but 46% of those parents in nonurban areas who were nonpoor and had a child with a clinical CBCL being identified as not having any of these risk factors.

Children in kinship care were the least likely (only 14%) to have parents who met the criteria of having none of these problems identified during the risk assessment (not shown in tables). Whereas children living in group home care (37%) and children who were in *other* placements (56%) (e.g., wilderness programs, hybrid placements that could not be easily classified, and placements with missing data) were most likely to meet these criteria (not shown in the table). The parents of children living in nonkinship foster care (18%) fell between these extremes, but were more similar to caregivers of children in kinship care. In other words, child welfare supervised children in group home care (although they had the highest proportion of behavioral problems) appear to come from families with the fewest traditional child welfare risks.

Although these data are too limited to offer precise estimates of the proportion of children who enter child welfare supervised out-of-home care in order to obtain mental health services, they can offer some broad estimates of those families entering out-of-home care with a partial reason of children's mental health problems. By looking at the universe of children with a borderline or clinical CBCL and considering the proportion of families, for each of those groups, without substance abuse, mental health, domestic violence, or trouble paying for basic necessities, we arrive at estimates that they comprise about 19% of children entering child welfare supervised out-of-home care. About 14% are urban/nonpoor children and about 5% are nonurban/nonpoor children. Against the more than 200,000 children who entered foster care in 2000 [Adoption and Foster Care Analysis and Reporting System (AFCARS), 2004] and were older than 2, this would be about 38,000 children. This could be considered an upward boundary because there are undoubtedly families who become involved with CWS because of other presenting problems. On the other hand, given the challenge of identifying this group, this could also be a conservative estimate.

These bivariate relationships are confirmed using logistic regression to test both an urban and a nonurban model (see Table 4). This shows the distinctive interaction between urbanicity, ability to pay for basic needs, problem behavior, age, and current parental problems (i.e., substance abuse, domestic violence, and mental illness).

The logistic regression shows that, in urban PSUs, the likelihood of placement because of the inability to pay for basic needs is a significant contributor to placement whereas it is not a significant

Table 4
Logistic Regression of Placement by Urbanicity, Ability to Pay for Basic Needs, Clinical/Borderline CBCL; Parent MI, SA, or Active DV, and Child Age

Variable	Urban (n = 2176)	Nonurban (n = 708)
	OR	OR
Intercept	.05	.02
Inability to pay for basic needs		
Yes	2.19**	1.37
No (reference)	1.00	1.00
CBCL		
Clinical/borderline	1.21	2.44**
Normal range (reference)	1.00	1.00
Child age		
3–5	.40*	.35
6–10	.70	.91
11+ (reference)	1.00	1.00
Parent MI, SA, or active DV		
Yes	5.60***	3.60**
No (reference)	1.00	1.00

Note. Cox and Snell pseudo-R^2 for Urban model = .09 and for nonurban model = .06. CBCL = Child Behavior Checklist; MI = mental illness; SA = substance abuse; DV = domestic violence.
* $p < .05$. ** $p < .01$. *** $p < .001$.

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factor in nonurban areas. In contrast, the likelihood of placement for nonurban children with a clinical/borderline CBCL score is significant and about twice as likely to be present among children placed in nonurban than for children placed in urban areas. When other factors are controlled for, age is not a significant contributor—except that 3- to 5-year-olds are least likely to be placed in urban areas. Parental problems are significantly associated with placement in urban and nonurban settings, but the association is much stronger in urban areas.

Conclusions

Children who enter the child welfare system are indeed much poorer than children in the general population. About half of children in out-of-home care and about a third of children receiving in-home services are identified by their child welfare worker as having been in families which had trouble meeting the basic needs of their children at the time of the investigation. Considerably more than half of all children involved in NSCAW have had a history of involvement with TANF/AFDC and about half live in households whose income falls below 50% of the poverty level. Among all in-home caregivers who receive ongoing CWS, about two thirds receive support through programs such as Food Stamps, WIC, TANF, SSI, or housing supports. Yet, this is clearly not the whole story, as an important subset of families is becoming involved with CWS for reasons other than poverty.

This argument to consider the heterogeneity in the child welfare population that brings in families that are not desperately poor or unfit, is not intended to minimize the adverse impact of having a low income on parenting. About one third of the families who receive CWS have trouble meeting basic needs. Many of the remaining families also have financial hardships. This analysis of families with open child welfare cases shows that even among the two thirds of the families not identified by child welfare workers as having trouble meeting basic needs, almost half live below the poverty level and the majority live below 150% of poverty.

The data cannot tell us that children do not become involved in CWS placements for reasons of poverty alone; however, the evidence is clear that this is far from the whole story. The relationship between poverty and placement varies markedly across urban and nonurban settings. Very poor children from urban settings were far more likely to enter placement than their other/nonpoor counterparts, but in nonurban settings there was no significant difference in the likelihood of placement by poverty status.

Ages of children have typically been the most significant factor in models explaining child welfare service dynamics. The age of the child has long been shown to have a very strong effect on placement characteristics in analyses conducted on administrative data (Barth, Courtney, Berrick, & Albert, 1994). Infants and adolescents are the age groups of children most likely to enter out-of-home care (Wulczyn et al., 1999). Age makes a less significant contribution, herein, probably because our analyses include estimates of children's behavior problems and of family poverty levels and both of these covary with age.

Poverty is clearly a significant and important contributor to placement of children away from their parents—especially if they are very young or living in urban settings. Prior analyses have confirmed the long-held conventional wisdom that children whose caregivers have one or more parental risk factors (mental illness, substance abuse, trouble paying for life's basic needs, or active domestic violence) are likely to receive higher levels of CWS than those who do not (U.S. DHHS, in preparation). What the current analyses show is that there are also a substantial number of families involved with CWS that do not have any of these problems. Overall, approximately 20% of caregivers had none of these problems—this is especially true of those families whose children are in group care. They were not the families often viewed as typical CWS recipients. Old assumptions that CWS are invoked for reasons of poverty alone, or even that they are for reasons of poverty combined with other parental problems do not hold here. CWS are frequently used as a way to provide care for older children with serious mental health problems.

The full extent to which the CWS fulfills the demand for placement among children who would otherwise be served in the children's mental health system has not been known. Although this use of CWS was understood (in the 1970s) as a central function of placement of children (Bernstein et al., 1975), the discussion of this topic has been largely limited to those children whose parents must relinquish custody of their child even though no maltreatment has occurred (Dewan, 2002; U.S. GAO, 2003). About 300,000 children, infants to age 18, entered out-of-home care in 2002 (AFCARS, 2004). The present estimate of 19% of children in NSCAW may be entering out-of-home care even though they do not have an obviously unfit parent. This yields an estimate of about 60,000 children entering the child welfare system under these circumstances.[2] This is a broad estimate of the proportion of children who may be entering out-of-home care for reasons primarily related to children's behavior problems; this is not an estimate of the smaller subset of CWS involved families who become ensnared by the red tape of involuntary custody relinquishments.

Children with serious mental health problems may enter child welfare placements in other ways. This seems to be especially common in nonurban areas among families that are nonpoor, and among families that are not, otherwise, multiproblem families (at least they are not experiencing the often-cited problem cluster of parental mental illness, substance abuse, or active domestic violence). We do not yet know the combination of factors that results in these kinds of placements, but this is an important puzzle to solve.

These findings can inform the actions and decisions of policy makers in several ways. For one, these findings can combat the inertia that has created a "one-age fits all" model for CWS design and evaluation. To assume that CWS agencies that serve a substantial proportion of older, mentally ill children will perform like CWS agencies that serve many younger and nonmentally ill children with more-often troubled parents is an unsafe assumption. Whereas states are slowly addressing the concerns raised by a few families that have been forced to give up custody of their children to CWS, the role of child welfare in meeting the needs of behaviorally disordered children is much broader.

[2] Although the NSCAW cases exclude children who enter out-of-home care during the ages of 0, 1, 15, 16, 17, and 18, this is unlikely to have a marked impact on the estimates because the very young children and older adolescents are roughly the same size groups (Wulczyn et al., 2005) with offsetting likelihoods of entering under these conditions.

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Many states are working to respond to the perceived need for more out-of-home care for children with mental health problems and doing so without requiring relinquishment of custody to CWS. At the time of writing, 13 states had outlawed the required relinquishment of custody to obtain placement services—requiring that either no such placement be made or that it be made voluntarily. Some of the most important policy strategies involve changes in insurance and the use of waivers to fund a broad array of services for ill or disabled children and are described in more depth elsewhere (e.g., Seltzer, 2003). Yet, these waivers do not expressly allow the payment for residential care for children with behavior problems. Furthermore, recent congressional testimony indicates that some states with waivers are barely using them for this population of children.

Child welfare policy can also make a difference by promoting the application of evidence-based community treatment services (Burns & Hoagwood, 2002) to children who are becoming involved with CWS. Child welfare policy can help to support demonstration programs to hasten the evolution of these services to address the needs of children involved with CWS. This will require retooling to see that these interventions—largely tested outside the child welfare system—can operate within the dimensions of child welfare service programs.

Our findings illuminate the enormous diversity in the dynamics of families entering out-of-home care. Much child welfare dialogue in the 1990s suggested a more monolithic family profile, with, for instance, the common wisdom indicating that all of the parents are poor and 80% of children entering out-of-home care because familial substance abuse had rendered their parent(s) unfit to provide safe care and supervision. Indeed, the general premise of CWS has based upon the notion that all of the involved parents are unfit to parent (Wulczyn, Barth, Yuan, Jones-Harden, & Landsverk, 2005). This diversity is complicated by geographic differences—at a minimum, urban and nonurban differences should be routinely included in analyses of child welfare service dynamics.

Yet the findings from this national probability study indicate that there are many other factors involved and that the historical use of out-of-home care for children with behavior problems has not disappeared. America's families need a children's service delivery system that is more differentiated and capable of responding to the broad needs of fit and unfit parents and behaviorally disordered children. CWS are moving tangentially toward such an approach, in their efforts to adopt new "multiple response" systems that divert families from court investigation services into voluntary services, whenever appropriate (U.S. DHHS, 2003). Such approaches were not designed for the purpose of addressing the needs of families that come to child welfare in need of help with the behavioral problems of their children. More of the discussion raised about the design and evaluation of multiple response systems should address the suitability for families with children with mental health disorders. Our analyses indicate that whether or not children and families are involved with CWS primarily because of children's mental health disorders should also be part of the diversion decision.

These data, and those recently gathered and reported by the U.S. GAO and others, suggest that the entire structure of child welfare and mental health services policy needs review. The idea that safety and permanency are the two overriding goals for all children who enter CWS does not fit these findings. Although judges can use discretion and waive certain permanency planning requirements in some cases and involuntary placement of children into out-of-home care is not necessary to draw down federal Title IV-E resources for the first 6 months of placement, these are small adjustments to a much larger problem. Child Welfare funding and policy are predicated on the notion that children are receiving services because of child abuse by unfit parents. Although this is predominantly the case, there is a sizable minority of cases that do not fit this pattern. Whereas many initiatives related to mental health services and insurance reform are endeavoring to improve care for these children, CWS also has a responsibility to participate in reforms that will lead to more fundamentally addressing the circumstances of these families.

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