

Child Welfare Fairness

**Parents' Pasts and Families'
Futures: Using Family
Assessments to Inform
Perspectives on Reasonable
Efforts and Reunification**

Cheryl Smithgall,
Jan DeCoursey, Duck-Hye Yang,
Lisa Haseltine

Recommended Citation

Smithgall, C., DeCoursey,
J., Yang, D., & Haseltine, L.
(2012). *Parents' Pasts and
Families' Futures: Using
Family Assessments to Inform
Perspectives on Reasonable
Efforts*. Chicago: Chapin Hall
at the University of Chicago.

ISSN: 1097-3125

© 2012 Chapin Hall
at the University of Chicago

Chapin Hall
at the University of Chicago
1313 East 60th Street
Chicago, IL 60637

773-753-5900 (phone)
773-753-5940 (fax)

www.chapinhall.org

Acknowledgments

This work is part of a cooperative agreement between the Illinois Department of Children and Family Services (DCFS) and the U.S. Department of Health and Human Services, Administration for Children and Families, Children’s Bureau. We appreciate the support—through funding and the sharing of information and resources—that both the Children’s Bureau and DCFS have provided to the evaluation team.

A significant part of this evaluation involved the analysis of information from databases maintained by DCFS. We are grateful for the opportunity to work collaboratively with staff from the DCFS Office of Information Technology and Services, without whose assistance this work would not have been possible.

Since the launch of this demonstration project, the composition of the project team has changed and many different DCFS staff have contributed to discussions of preliminary data and the policy and practice implications. We are grateful to all the current and former DCFS staff who participated at various points in this process: Hector Aviles, Jacqueline Bratland, Valleria Forney-Williams, Melissa Frank, Paul Langevin, Brenda Owen, Larry Small, Jill Tichenor, Kelly VanOverbeke, and Douglas Washington. We are also thankful for the opportunity to engage the Integrated Assessment contract agency directors at Northern Illinois University, Southern Illinois University, and LaRabida Children’s Hospital in meaningful discussions about the assessment program.

Because of confidentiality assurances, we cannot name the IA screeners, caseworkers, or supervisors whose work is reflected in the assessments; however, we are grateful for their day to day efforts as well as their participation in meetings and interviews for the evaluation. They have contributed immensely to our understanding of the contexts and processes surrounding the IA program and our perspectives on the children and families served by DCFS.

Table of Contents

Introduction	4
Contribution of the Current Study.....	5
Methods	7
Study Sample	7
Data from the Integrated Assessment Reports	8
The Child and Adolescent Needs and Strengths (CANS) Tool	10
Analytic Approach	10
Findings	12
Parents’ Childhood Experiences and Recall of Traumatic Experiences	12
The Character of the Childhood Trauma	16
Exploring Parents’ Traumatic Experiences through a Developmental Lens.....	16
Parents’ Functioning as Adults Given their Reported Childhood Experiences	18
Parents’ Educational Attainment and Stability of Employment	19
Parents’ Current Service Needs	20
Parents’ Awareness of and Willingness to Change Maladaptive Behaviors	20
Prognosis for Reunification.....	23
Reunification Outcomes and Subsequent Placements	24
Study Limitations	25
Discussion.....	27
Implications for Parent Engagement in Child Welfare Systems.....	28
Implications for Intervention Design and Service Arrays.....	28
Implications for Child Welfare Policies.....	29
Conclusion	30
References	32

List of Tables

Table 1. Regional distribution of family cases	8
Table 2. Percentage of parents whose interviews affirmed ACE items.....	13
Table 3. Characteristics of parents with high and low ACE scores.....	15
Table 4. College attendance and employment history for parents with high and low ACE scores.....	19
Table 5. CANS Assessment of parent service needs for parents with high and low ACE scores	20

Introduction

Whether parents can overcome the problems that led to abuse and neglect of their children is the essence of questions surrounding efforts to return children to their parents once legal custody of a child has been granted to the child welfare agency. Consistent with a legal and policy framework protecting parental rights in the United States, the threshold for separating a child from his or her parents is set high, and family reunification is the preferred permanency goal for most children who come into the child welfare system. Despite this policy preference, reunification rates are lower than desired and even when reunification does happen, some children experience subsequent placements.

Low reunification rates raise important questions: Is a deeper understanding of parents' functioning necessary in order to better address the needs of parents and families and improve reunification efforts? How might that deeper understanding inform perspectives on reasonable efforts, defined as the "activities of State social services agencies that aim to provide the assistance and services needed to preserve and reunify families" (U.S. Department of Health and Human Services, 2009). In his developmental framework for understanding psychopathology, Sroufe (1997) outlines a couple of key ideas that are particularly relevant as we grapple with these questions. First, the problematic functioning of any individual is less apt to be a result of one singular experience and more likely to have evolved over time as a result of successive experiences. Second, and related to that, a significant, negative experience at one point in time may increase the difficulty a person has in negotiating and successfully accomplishing a subsequent developmental task. Third, a return to positive functioning is always possible; however, the longer a maladaptive pathway has been followed, the less likely it is that the person will reclaim the ability to function positively. This framework suggests that it is critical that we seek to understand the pathways that parents have taken up to the point of involvement with the child welfare system. In fact, the pathway itself is a source of clinically meaningful information that has implications for engagement, treatment, and outcomes.

Recognizing the value of understanding those pathways, child welfare agencies in some states have begun to move away from narrowly focused safety assessments. In 2005, the Children’s Bureau developed comprehensive family assessments (CFA) guidelines that are intended to facilitate an understanding of the whole situation that precipitated child welfare involvement, including a focus on patterns of parental behavior over time and the contexts in which those behaviors have developed (Schene, 2005). Research indicates that child welfare systems’ use of early family engagement and assessments is associated with many positive family outcomes, including higher levels of reunification, reduced re-abuse, increase in kinship placements, and increased placement stability (Child Welfare League of America, March 2002; Merkel-Holguin, Nixon, & Burford, 2003; Titcomb & LeCroy, 2003; Wheeler & Johnson, 2003).

The Illinois model of CFA—referred to as an integrated assessment (IA)—is one component of a family-centered, trauma-informed, strengths-based practice model. The reports produced from these assessments offer a unique research opportunity to explore how factors from multiple domains of the child’s life and of the adults involved with him or her may relate to individual or family outcomes. Perhaps a unique aspect of the IA program vis-à-vis the CFA guidelines is that it takes into consideration the experience of childhood trauma for both children and their parents. Theories of child trauma offer explanations for how particular experiences can disrupt neurodevelopment and psychosocial development and result in multiple problems, including medical and mental health problems and disruptive behaviors (Perry, 2001; Putnam, 2006). Public sector agencies can use research on normal child development and the impact of trauma to drive methods of prevention, early intervention, treatment and follow-up care and support the goal of return to normal development (Griffin & Studzinski, 2010). While frameworks drawing on trauma and child development are increasingly being acknowledged in discussions of child serving systems, they are less frequently applied to understanding and working with parents.

Contribution of the Current Study

In this study, assessments conducted as part of the Illinois integrated assessment program allow us to look at a subset of parents for whom reunification might seem unlikely given their own personal histories and extensive exposure to trauma. Using a sample of narrative assessment reports drawn from the IAs, we explore the nature and prevalence of traumatic experiences among biological parents whose children were placed in the custody of the Department of Children and Family Services (DCFS). The relationship between parents’ childhood experiences and their current functioning is explored, as are data on reunification outcomes.

The findings that a subset of parents involved with the child welfare system have extensive childhood trauma experiences and present with multiple problems or service needs have implications for caseworker engagement as well as interventions. We examine what caseworkers and clinicians see as the initial prognosis for these families as well as the reunification and reentry outcomes after the children entered foster care. We hope to encourage dialogue about what policies and practices might need to be developed and implemented in order to improve long-term child and family well-being outcomes for this particular group of families. The study raises fundamental questions about our obligation to and approach to protecting children and to promoting their well-being.

Methods

This evaluation utilizes a mixed-methods approach, drawing on several administrative databases maintained by the Illinois Department of Children and Family Services (DCFS) as well as an analysis of in-depth assessment reports jointly produced by caseworkers and Integrated Assessment Screeners. The databases and sampling procedures are described below. Protocols detailing procedures for protecting human subjects and maintaining confidentiality of data were approved by Institutional Review Boards at both the University of Chicago and the Illinois Department of Children and Family Services.

Study Sample

The sampling frame for this study included all families with children who entered foster care in 2008 and were referred to the IA program as standard placement cases ($N = 1,764$ families, 2,820 children). A standard case is one in which DCFS does not provide services to the family prior to the decision to place the child or children in foster care. In other words, the initial report and investigation of maltreatment leads to a child's immediate removal from his or her home.¹ From this set of 1,764 families, 100 family cases were selected for this study. Data on family composition and relationships among family members were not available in the administrative data used for selecting the sample. The initial sample of 100 family cases were randomly selected; however, six families were excluded because the child's placement was in the home of a parent (DCFS was awarded custody, but the child remained in the home), and four families were excluded due to incomplete IA reports. Ten replacement cases were also randomly selected. Of the 100 family cases in which a child was in an out-of-home placement and for which an IA report was

¹ Data indicate that between 2005 and 2008, standard placement cases comprised 46 to 53 percent of DCFS child placement cases annually.

completed, 15 families were excluded from this study because no biological parent was interviewed as part of the assessment, leaving a final sample of 85 families. Table 1 shows that the regional distribution of families in the study sample is generally reflective of the larger population of cases for 2008, with a slight underrepresentation of families in the Cook region and overrepresentation of families in the Southern region. The race and ethnicity of the parents in the study sample were 62% Caucasian, 31% African American, 6% Latino, and 1% multiple race/ethnicity. Although the proportion of African American parents is lower than anticipated, it is perhaps reflective of the underrepresentation of the Cook region, which includes the city of Chicago and surrounding suburbs.

Table 1. Regional distribution of family cases

Region	Study Sample (%)	2008 IA cases (%)
Northern	25	25.7
Central	33	30.3
Southern	25	17.3
Cook	18	26.7

Among the 85 families in the study sample, assessments were completed with 140 biological parents—80 mothers and 60 fathers—who were parenting 176 children ages 0 to 17.² The vast majority (81%) of these families had only one or two children included in the household membership.

Data from the Integrated Assessment Reports

The Illinois DCFS Integrated Assessment is designed to look at the medical, social, developmental, mental health, and educational domains of the child and of the adults who figure prominently in the child’s life. When the initial assessment is completed as part of the IA program, child welfare caseworkers and licensed clinicians interview the children and adults and gather and review all investigation screenings, past provider assessments, background reports, treatment and school records, and other case documentation. An extensive semi-structured interview protocol guides the interview and report writing process and covers the following topics:

² Each parent had at least one biological child in the family case; however, it is possible that a parent may have been a step-parent to another child in the home or a paramour.

- Parent's personal history (includes questions about the home environment and the parenting he/she experienced as a child as well as questions that align with the ACEs questionnaire³)
- Education and cognitive functioning (asks about highest level of education completed but also how he/she did in school and relationships with peers and teachers)
- Employment history (specifically asks about longest time on one job as well as whether he/she encountered problems with coworkers or bosses or went to work under the influence)
- Parent's social/romantic relationships (includes age at first romantic relationship, marital status, nature of current relationship and the relationship with each child's father/mother, if applicable)
- Parent's criminal behavior and background (IA screeners are directed to give consideration to patterns of behavior over time as well as parents' characterization of or response to the impact of their criminal behaviors)
- Substance use history
- Medical/developmental conditions
- Emotional functioning
- Parent's current living arrangement/housing
- Resiliency factors (sense of humor, perseverance, self-worth, and inner direction and parents' skills or talents)
- Support system (not just who is a source of support but what that person does that is supportive)
- Understanding of role as a parent (differentiation from their own experiences growing up, improvements needed, obstacles, effective or ineffective discipline practices, structure of family's daily life/routines, and perceived strengths of each child)

The information gathered during the assessment process is then integrated into a report about child and family history, including their strengths, the support systems available, the service needs for each child and adult, overall family functioning, and the prognosis for reunification. The report is to be completed within 45 days of the child being taken into custody. The information in the IA report and the

³ Information on the Adverse Childhood Experiences Study and the ACEs questionnaire can be found at: <http://www.cdc.gov/ace>.

collaborative process between caseworker and IA screener are intended to lead to earlier and more appropriate interventions for the child and family. For this study, both the parent interview and family functioning sections of the assessments were coded and analyzed.

The Child and Adolescent Needs and Strengths (CANS) Tool

The CANS tool is a measure of psychological well-being, the need for services and intervention, and strengths. The CANS has multiple applications, including (1) decision support, (2) treatment planning, and (3) outcomes management (Lyons, 2004). It is desirable for these functions because of its ease of use and high inter-rater reliability among certified raters (Anderson & Huffine, 2003). The CANS is a particularly useful gauge of need for services as individual items are scored on a four-point scale according to the need for intervention to address the issue the item captures. A score of 0 indicates no need for action, and score of 1 suggests monitoring to ensure that no problem arises in the area, a score of 2 indicates the need for intervention, and a score of 3 indicates a need for immediate and/or intensive intervention to address the issue. Accordingly, analyses of CANS data for research purposes routinely dichotomize the rating scale for each item into “actionable” (a score of 2 or 3) and “non-actionable” (a score of 0 or 1) (Lyons & Weiner, 2009). The purpose of the 14 items in the caregiver domain of the CANS is to assess the extent to which the caseworker indicates concern about the caregiver’s ability to meet the child’s needs, presumably identifying needed supports or services where concerns are noted. The 14 items in the caregiver CANS domain include: Physical Health, Mental Health, Substance Use, Developmental Disability, Supervision, Involvement with Care, Knowledge, Organization, Resources, Residential Stability, Safety, Marital/Partner Violence, Caregiver Post Traumatic Reactions, and Criminal Behavior. For the cases included in this study, the CANS assessments were completed as part of the initial Integrated Assessment, and information needed to complete the CANS was obtained from biological parents during the IA interview process.

Analytic Approach

For the qualitative analyses, the authors developed an initial coding scheme based on the content areas of the DCFS Integrated Assessment report template and published literature about childhood trauma and adult manifestations of childhood trauma. Two analysts reviewed four Integrated Assessment reports and labeled units of text, such as a phrase, sentence, or paragraph, using the initial coding scheme. Coded reports were then reviewed by the team and discussed until a consensus emerged, resulting in a set of broad, not mutually exclusive, coding categories that were applied using Atlas.ti.

When coding was complete, the authors further refined the themes and findings that emerged and tracked them through charts of code content and contextual narrative, creating qualitative data displays (Miles & Huberman, 1994). Themes were summarized through memo writing, which became a source of meta-data (Miles & Huberman, 1994). Quotations used to support these themes were drawn from Atlas.ti and identification codes for quotations were tracked throughout the development of the results and writing of the final paper to ensure that no single participant was overrepresented.

At several points in the analysis, the authors also developed quantitative codes that were used to capture and summarize the prevalence of parent experiences and themes and to compare subgroups (Cresswell, Plano Clark, Gutmann, & Hanson, 2003). In particular, the narrative of the biological parent assessments were reviewed for data affirming the parents' experience of any of the 10 Adverse Childhood Experiences captured in the ACEs short form. The cumulative score from the ACEs short form was then entered into SPSS v17. The SPSS file also contained background and demographic characteristics of the parents, data extracted from the 14 items of the caregiver domain of the Child and Adolescent Needs and Strengths (CANS) tool used by clinicians and caseworkers in the Integrated Assessment, and data on the placement and discharge outcomes for children in these families.

Findings

This section details findings on the extent and nature of multiple and chronic interpersonal trauma experiences reported by a sample of biological parents whose children were placed in the custody of the Department of Children and Family Services. We also explore the relationship between parents' self-report of adverse childhood experiences, aspects of risk and protective factors throughout these parents' lives, and their current functioning and parenting as captured in the initial assessment conducted jointly by child welfare caseworkers and licensed clinicians. Finally, we look at the family prognosis section of the initial assessments and the reunification outcomes for families in this study.

Parents' Childhood Experiences and Recall of Traumatic Experiences

In designing the interview protocol that screeners for the Integrated Assessment program use, the developers of the DCFS IA program took into consideration the topics covered in the questionnaire about adverse childhood experiences that was used in the ACEs study (Felitti et al., 1998; <http://www.cdc.gov/ace/index.htm>). Those topics include verbal, physical, or sexual abuse, as well as family dysfunction (e.g., an incarcerated, mentally ill, or substance-abusing family member; domestic violence; or absence of a parent because of divorce or separation). Table 2 shows the percentage of parents who, in their initial assessments with the IA program, disclosed experiences affirming the ACE items.

Table 2. Percentage of parents whose interviews affirmed ACE items

Adverse Childhood Experiences Definitions and Questions ⁴	#	%
Emotional Abuse Did a parent or other adult in the household often or very often ... Swear at you, insult you, put you down, or humiliate you? or Act in a way that made you afraid that you might be physically hurt?	21	15
Physical Abuse Did a parent or other adult in the household often or very often ... Push, grab, slap, or throw something at you? or Ever hit you so hard that you had marks or were injured?	40	29
Sexual Abuse Did an adult or person at least 5 years older than you ever ... Touch or fondle you or have you touch their body in a sexual way? or Attempt or actually have oral, anal, or vaginal intercourse with you?	39	28
Emotional Neglect Did you often or very often feel that ... No one in your family loved you or thought you were important or special? or Your family didn't look out for each other, feel close to each other, or support each other?	30	21
Physical Neglect Did you often or very often feel that ... You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? or Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?	29	21
Parental Separation or Divorce Was a biological parent ever lost to you through divorce, abandonment, or other reason ?	93	66
Mother treated violently Was your mother or stepmother: Often or very often pushed, grabbed, slapped, or had something thrown at her? or Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard? or Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?	40	29
Substance abuse Did you live with anyone who was a problem drinker or alcoholic, or who used street drugs?	59	42
Mental illness Was a household member depressed or mentally ill, or did a household member attempt suicide?	32	23
Criminal behavior in household Did a household member go to prison?	30	21

The most prevalent types of adverse childhood experiences among this group of parents were the loss of a parent and living with someone who had a problem with alcohol or drugs; over one-quarter of parents experienced the following: physical abuse, sexual abuse or domestic violence.

⁴ Definitions were accessed July 17, 2012 at <http://www.cdc.gov/ace/prevalence.htm>; some of these items were asked in the second survey wave only and thus do not appear in Felitti et al., 1998.

The ACE Score—which is a count of the total number of adverse experiences respondents reported—is used to assess the total amount of stress during childhood. High ACE scores—defined as 4 or more—have been found to be associated with risk of health problems and premature death (Felitti et al., 1998). Over a third (37%) of parents in this sample had ACE scores of 4 or more. That is triple the prevalence reported in the original ACE study.⁵ With respect to the parents in this sample, Table 3 compares those parents who reported high ACE scores (4 or more items) with those who had low ACE scores (fewer than four items). A significantly greater proportion of the parents with a high ACE score were mothers ($X^2 = 7.8$, $df = 1$, $p = .005$), and having a high ACE scores was significantly associated with past involvement with DCFS as a child ($X^2 = 26.7$, $df = 1$, $p \leq .001$).

⁵ <http://www.cdc.gov/ace/prevalence.htm>

Table 3. Characteristics of parents with high and low ACE scores

	Parents with fewer than 4 ACEs (<i>N</i> = 88)	Parents with 4 or more ACEs (<i>N</i> = 52)
	Percent	Percent
Region		
Central	35	35
Cook	19	13
Northern	27	23
Southern	18	29
Sex/Relationship of Parent		
Mother (vs. Father)	48	73
Parent Age		
Under 21	4	15
21-25	15	19
26-30	23	25
31-40	42	27
Over 41	16	14
Previous DCFS Involvement		
Prior involvement in DCFS as a child	2	33
Prior involvement in DCFS as a parent	32	33
Race/ Ethnicity		
Caucasian	53	77
African American	40	15
Latino	6	6
Multiple Race/ Ethnicity	1	2
Number of Children in the case		
1	56	42
2	27	35
3 or more children	17	23

Throughout the remainder of this paper, we continue to compare these groups of parents with high and low ACE scores, in order to develop a more contextualized understanding of the experiences of those with high ACE scores. For that reason, the qualitative data are drawn from the subset of parents with four or more ACEs, which represents 52 biological parents from 45 family cases that include 94 children. The qualitative data are used to look at the development over time of the parents with high ACE scores, including rich information about their experiences and the circumstances surrounding them. Bivariate quantitative analyses reinforce the fact that these parents with high ACE scores represent a distinct

subgroup for several different markers, such as educational attainment, employment, current functioning, and case outcomes with the child welfare system.

The Character of the Childhood Trauma

The full narratives from which the ACE items were scored include extensive descriptions of the traumatic experiences that were prevalent in the assessments for parents with high ACE scores. They underscore the scope and severity of the experiences of this particular group of parents. In addition to the trauma described through the ACE items, several parents described such experiences as repeated housing instability including multiple moves within the child welfare system, a chronically or terminally ill family member, and negative reactions to community violence and poverty. Furthermore, the narratives revealed a high level of severity in some cases. Just over one-fifth of those parents with high ACE scores experienced an extreme level of violence that included witnessing murder or attempted murder; this type of violence is well in excess of the pushing, grabbing, or threatening with a weapon that is described in item 7 of Table 2.

[Father] reported that his mother was murdered by his father during an incident of domestic violence. Father reported that his father was an alcoholic who was frequently physically, verbally, and emotionally violent toward his mother. He reported that his mother would frequently leave the home with the children when his father was drunk. Father reported that his father became angry on one occasion when his mother left the home. He followed them to his grandmother's house where his father shot his mother. He was 6 years old when his mother was killed. Father reported that he was exposed to violence and violent neighborhoods throughout his childhood and reported seeing people murdered.

Mother and her siblings witnessed a significant amount of violence. She recalled watching her mother being dragged down the road with her arm caught in the car door, her father putting a gun in her mother's mouth, and being locked with her mother and siblings in the basement by her father.

The items captured in the ACEs short form do not capture all of the types of trauma a child may experience. In thinking about building a collaborative framework for public health surveillance of adverse childhood experiences, some experts have recommended the original set of experiences be expanded (Anda, Butchart, Felitti, & Brown, 2010). Consistent with that recommendation, the ACE scores of many of these parents appear to under-represent their full set of adverse childhood experiences.

Exploring Parents' Traumatic Experiences through a Developmental Lens

The narrative assessment reports also detail the parents' recollection of the response to the trauma and the ways in which those traumatic experiences may have framed or influenced their behaviors in adolescence.

Although their recall of the age at which incidents occurred may be less reliable than the fact that they occurred, it is noteworthy that three-quarters of the parents with high ACE scores recall their experiences beginning in early childhood. When describing abusive experiences of any kind, many of parents reflected on their perceived lack of access to trustworthy and supportive relationships from other adults who could play a protective role (see underlined text in the excerpts below, emphasis was added for the purposes of this paper).

[Father's father] died of a brain aneurysm when [father] was 7 years old...[Father] said that he had a difficult childhood because his mother remarried right after his father died and he was not allowed to grieve the loss of his father...There was domestic violence in his mother's relationship (with his stepfather). [Father] said that he was physically and mentally abused by his stepfather throughout his childhood...while his two siblings were not. *He felt that his mother was resentful toward him* when he did not accept his stepfather. He said that the physical abuse, toward him alone, continued until he moved out of the home at age 17.

[Mother] said that her father sexually abused her from age 3 or 4 until she was 15 years old, at which time she went to the police and became involved with the DCFS. When [Mother] initially told her mother that her father had been sexually abusing her, her mother responded by taking her and her siblings to southern Illinois for 3 weeks. After 3 weeks they returned to her home and the sexual abuse between [Mother] and her father resumed immediately. That was when [Mother] went to the police with her problem. At age 15, she was removed from the home for about eight months and lived with her aunt. She returned home until she was 18 when she moved away again. She also said that her father sexually abused her sister closest to her in age. *Her father has never acknowledged the sexual abuse and the family does not believe [Mother]'s assertions.*

Mother recalled [being] raped from the ages of 7–13 by an uncle. At age 13, her step-father was sent to prison for manufacturing meth. At age 13 says life turned into “hell.” *She felt there was no parent in the house to protect her.* She recalls that although her mother kept her, she did not show her any love and she did not provide the things she needed while growing up.

Not only did these parents lack access to an adult who would act in a protective role, but in many cases the adults in their lives seemed to exert a negative influence. Many of the parents with high ACE scores reported that they began drinking during pre-adolescence or were drug addicted early in adolescence, and their stories draw attention to the family dynamics and the behaviors of these parents' parents that presumably factored into their use or abuse of drugs and alcohol in adolescence.

[Father's] parents divorced when he was 2 years-old. . . Father did not see his father for 10 years following the divorce. . . (After the divorce), he was cared for by his maternal grandparents, where he

remained until he was 5 or 6. . . Father's mother abused alcohol during his childhood which resulted in D.U.I.s. . . Father was placed in psychiatric hospitalizations "several" times during his childhood beginning at the age of 7. He was sexually abused at the age of 10 or 11 by an 18-year-old female babysitter. . . . (After living with his grandparents), he was primarily cared for by his mother until [age] 14 or 15. At the age of 13 or 14, he began, "running with the wrong crowd," using drugs and experienced legal problems. [Father's] first romantic relationship was at the age of 14. At that time, he became involved with a 27-year-old female and moved from his mother's home to hers'. He was involved in a sexual relationship with this person for approximately 1 year prior to her moving.

[Mother's] stepfather called her derogatory names and her mother was described as a "screamer". . . The family never had any money and her mother smoked marijuana instead of taking care of the household. . . Mother's stepfather smoked marijuana with mother and her sister. Mother began smoking marijuana when she was about 11 or 12 years old and added that her stepfather introduced her to marijuana. She resumed smoking marijuana when she was 15–16 years old and "whenever it was available—everyday."

Mother started drinking every day at age 14 and stopped at age 17. She first tried marijuana at age 14 and consumed the substance every day for an extended period of time. When asked to describe her current patterns of marijuana use, mother described her use as "off and on," which involves smoking it for a month and refraining for a 2-month period. She first tried cocaine at age 18, after her stepfather introduced her to it. She currently uses cocaine 2–3 times per week.

The presence of or relationship between childhood experiences and use or abuse of substances during adolescence is consistent with research from the ACEs study funded by the Center for Disease Control (CDC) that shows a strong relationship between the total number of ACEs and initiating alcohol use during early adolescence (Dube, Miller, Brown, Giles, Felitti, Dong, & Anda, 2006).

Parents' Functioning as Adults Given their Reported Childhood Experiences

We now shift from a reflection on childhood and adolescence to the assessment of parents' current functioning. Research indicates that adult survivors of childhood trauma may have difficulties with regulation of affect and impulses, memory and attention problems, self-perception, attachment and interpersonal relations, somatization, and systems of meaning (Cook et al., 2005; Van der Kolk, Roth, Pelcovitz, Sunday & Spinazzola, 2005). According to the National Childhood Traumatic Stress Network, parents' own histories of trauma affect not only their ability to care for their children but also their ability to work effectively with their caseworker (National Childhood Traumatic Stress Network, 2011). In this section, we explore how their own childhood trauma may be associated with parents' problems with school, maintaining employment, needs for services, and willingness to change maladaptive behaviors.

Parents' Educational Attainment and Stability of Employment

Educational attainment is seen as critical in the transition to adulthood and strongly associated with employment prospects. However, parents who experienced extensive trauma in their childhood—often accompanied by residential mobility and dysfunctional relationship patterns—may also struggle to complete their primary education. Table 4 shows the percentage of parents—grouped according to whether they had 4 or more ACEs—who report attending some college and maintaining stable employment. The group of parents with 4 or more ACEs reported significantly lower educational attainment ($X^2 = 7.0$, $df = 1$, $p \leq .01$), and fewer of these parents had a stable employment history ($X^2 = 7.1$, $df = 1$, $p \leq .01$).

Table 4. College attendance and employment history for parents with high and low ACE scores

	Parents with fewer than 4 ACEs (88)		Parents with 4 or more ACEs (52)	
	<i>N</i>	%	<i>N</i>	%
No college	47	53	40	77
Stable employment history	35	40	9	17

Parents experiencing financial and employment problems also identified a sense of urgency in addressing those particular problems and prioritized them over participation in physical or mental health services.

[Father saw his father shoot his mother]. . . He was 6 years old. . . After his mother's death, he lived with his maternal grandmother and his aunts and uncles. . . [where] he was "whooped" with extension cords and belts. Father. . . reported that he started getting into trouble during high school and dropped out of school. He also reported that he has been involved with selling drugs and criminal activity for a long time. Father reported that he was exposed to violence and violent neighborhoods throughout his childhood and reported [he saw] people murdered. . . Father reported that he has disturbing memories of his mother's murder and that these memories enter his mind several times a week. . . Father evidences depression and anxiety. . . and possible unresolved grief and trauma issues and responses. . . [Father] reported that he needs to get out of jail, obtain a job, and obtain housing to care for his children. He does not believe his family is in need of further services.

When parents face challenges in prioritizing services as well as meeting basic needs, the caseworker may need to work with the parents to understand how their past experiences relate to current functioning. They will need to work together on how to develop and implement a service plan that addresses a more comprehensive picture of the parents' needs and strengths, hopefully leading to sustainable changes and improved individual and family functioning. It may be difficult to establish realistic timelines for this

particular group of parents to make progress; moreover, these timelines may not fit with ASFA timelines for reunification or termination of parental rights.

Parents’ Current Service Needs

When a child is placed in the state’s care, an assessment is made of the parents’ ability to meet that child’s needs. To further examine the association between childhood trauma experiences and adult functioning, we look at two factors: the ACEs Score and certain caregiver CANS items. We compared parents with fewer than and more than four ACEs, and explored documented “actionable” concerns on select caregiver CANS items related to problems perceived to be frequently occurring among parents involved with child welfare (see Table 5).

Table 5. CANS Assessment of parent service needs for parents with high and low ACE scores					
	Parents with fewer than 4 ACEs (N = 71)	Parents with 4 or more ACEs (N = 48)			
	%	%	X ²	df	p-value ≤
Mental Health	27	71	21.9	1	0.001
Substance Use	39	54	1.9	1	0.17
Resources	34	44	1.6	1	0.21
Residential Stability	27	50	7.2	1	0.007
Marital Partner Violence	30	46	4.2	1	0.04
PTSD	10	38	11.7	1	0.001
Three or more of these CANS items	58	79	5.3	1	0.02

Concerns about parents’ mental health, residential stability, marital partner violence, and experiences of PTSD were noted for a significantly greater percentage of parents with 4 or more ACEs. A significantly greater percentage of parents with 4 or more ACEs also present with three or more “actionable” CANS items. This snapshot focuses on the problems that screeners and caseworkers identify that should be acted upon *immediately* with a referral for services; thus, for a significant number of parents who experienced 4 or more ACEs, there is a need not only for connections to effective services that address individual problems, but also for coordination across services or, perhaps, prioritization of which services should be completed first.

Parents’ Awareness of and Willingness to Change Maladaptive Behaviors

Prochaska and DiClemente’s Transtheoretical Model of Behavior Change highlights the importance of not only identifying and accepting the need to change but being able to envision what that change looks

like, achieving decisional balance (where the advantages of change are perceived to outweigh the disadvantages), and gaining confidence that the change can be sustained despite being in a context that may cause one to revert to previous behaviors (Prochaska & DiClemente, 1984).

In the assessment reports of parents with high ACEs, caseworkers and IA screeners captured connections between parents' past experiences, their current functioning, their willingness to participate in services, and their ability to appropriately protect and care for their children. The willingness to participate in services was consistently noted and emphasized in the overall case formulation of the issues that need to be addressed.

[Mother] was able to identify the struggles that she experienced during her childhood and the impact on her current functioning. . .[Mother] was able to identify that she continues to struggle with depression and substance use. She identified that she needs therapeutic services to help address the substance use, which has impacted the current situation. . .She experiences feelings of guilt related to the current situation. She expresses some awareness of the impact the substance use may have on her parenting and therefore her children. . .However, she continues to abuse substances and has failed to appear for three scheduled visits with her children.

The couple denied the existence of violence in their relationship. However [father's law enforcement arrest record] revealed an unacknowledged domestic battery which occurred after [mother and father] began dating. The couple denied any ongoing alcohol or substance abuse issues, but [mother] acknowledged testing positive for marijuana [this year]. . . .Both parents have verbalized their desire for the children to be returned home; however, they both failed to verbalize their willingness to participate in the recommended services.

[Father] has a substantial history of violence, the official documentation of which begins [21 years ago]....It is believed that his tendency towards violence and interpersonal conflict is directly related to his consumption of alcohol. Unfortunately, despite being aware of the connection between the two, that awareness does not appear to have resulted in any lasting behavioral change. Currently, [father] asserts that he is going to abstain from further alcohol use, although he has made similar statements on numerous occasions in the past. Despite recent and pending criminal charges and his daughter's placement into foster care, [father] has not actively pursued any type of substance abuse treatment on his own which may suggest insufficient motivation for change. . . . However, if [father] readily engages in the programs and services outlined above and demonstrates motivation toward his goals, his circumstances and/or ability to provide the safety, permanency, and wellbeing of [child] may improve.

Despite being aware of connections between past experiences and current problems, a majority (79%) of the parents with 4 ACEs or more were identified as resistant to participating in services to address their

current problems functioning as adults and as parents. The reluctance to participate in services may indicate these parents have not accepted the need to change, but it may also reflect their assessment of the benefits of participating in services, an assessment that may be influenced by past experiences. More than two-thirds of the parents with 4 or more ACEs described having participated in treatment for mental illness or other concerns related to their mental health. One-third of these parents had experienced a psychiatric hospitalization, with some having had their first hospitalization in their childhood or adolescence.

[Mother] reported two psychiatric hospitalizations at [Medical Center]. Case records indicate she was hospitalized for an increase in depressive symptoms, including suicidal ideation and an eating disorder. She was placed on an eating disorder unit. [Mother] has been cooperative with individual chemical dependency therapy. [Mother also] reported attending sporadic mental health services over the past several years.

[Father] reported that he was psychiatrically hospitalized two times as a child. He reported his first hospitalization to have been when he was 12 or 13 years old. . . [Father] stated that he was hospitalized for several years. He reported his second hospitalization to have been when he was 16 or 17 years old. He stated that he was again hospitalized for several years. [Father] was unable to identify any mental health or behavioral problems he was having that contributed to his hospitalizations. He also was unaware of any diagnoses. [Father] reported that he has had no other mental health services.

[Father] described symptoms of depression, which began during his childhood. He has been placed in multiple psychiatric hospitalizations beginning at the age of 7. He has been diagnosed with bipolar disorder and ADHD. . . Father has a long history of illegal substance use and has participated in multiple treatment programs, but continues to use marijuana as a method of self-medicating.

It is not clear from the assessments how these parents have come to understand the reasons for the successes or failures of previous efforts to participate in treatments or services. Thus it is challenging—but important—to sort out the extent to which barriers to parents' engaging in and completing services can be attributed to parents' attitudes, workers' approaches to engagement, the quality and availability of providers, or the effectiveness of particular treatments. Other studies have demonstrated that the expectations about service and the "fit" with what is being provided have implications for treatment retention as well as barriers to future use (Kerkorian, McKay, & Bannon, 2006; Gopalan et al., 2010; Yeh & Weisz, 2001).

Prognosis for Reunification

Data from multiple states confirm that the most frequent type of exit from foster care placement is reunification, with approximately two-fifths of children from more recent cohorts returning to their parents' care (Wulczyn, 2004; Wulczyn, Chen, & Hislop, 2007). However, reunification is particularly challenging when parents are facing multiple or compounded problems (Littell & Schuerman, 1995; Marsh, Ryan, Choi, & Testa, 2006), as is likely the case for many of the parents with 4 or more ACEs.

As part of the Integrated Assessment process, caseworkers and screeners synthesize and incorporate information into the Integrated Assessment report to inform service recommendations and case planning. In doing so, they are specifically instructed that unless contraindicated, the goal should be for the family to reunite. For the families in this study in which at least one parent reported 4 or more ACEs, the assessment report included a statement specifically noting that the prognosis for reunification was *poor*, *unlikely*, or *unfavorable* for roughly one-third of the cases; *guarded* for another one-third of the cases; and *favorable* for a third of the cases. In the statements about prognosis, screeners and caseworkers wrote fairly lengthy explanations that integrated aspects of individual and family functioning with availability of and attitudes toward services.

It appears that the early life experiences of [mother] and [father] taught them to function in dysfunction. Both were exposed to parental substance abuse, abandonment, and neglect. . . . The extended family appear to aid these parents in the continuance of drug use. . . . The support that exists. . . is weakened by conflict and the multigenerational culture of substance abuse. . . . [Mother] and [father] have verbally committed to doing whatever they need to do in order to be reunified with their children; [mother] has, in fact, individually initiated substance abuse treatment. . . . The probability of [reunification] appears favorable based on [mother's and father's] expression of commitment to their children and their heretofore willingness to cooperate with current services.

The communication patterns in this family are limited and there appear to be boundary issues present in [mother's] extended family. . . her day to day functioning seems quite chaotic and erratic likely due to her difficulty managing her mental illness. . . [mother] has a history of failing to cooperate with psychiatric/mental health treatment, leaving her symptoms unmanaged and leaving herself more vulnerable to erratic behavior and serious symptoms of psychosis. . . . [Father] presents his own psychiatric/mental health problems and has also suffered a traumatic brain injury. . . . [Mother and father] appear to have difficulty with interpersonal interactions as they are unable to regulate their thoughts and emotions in a stable and healthy manner. They have likely experienced chaos in their relationship. We offer a recommendation for reunification. . . pending active involvement with recommended services. The probability of this permanency goal accomplishment appears favorable

based upon [mother's] expression of commitment to raise her child and her heretofore willingness to cooperate with recommended services.

The family appears to have difficulty accepting responsibility and identifying problems. [Mother and Father] were unable to identify any problems within their family and are angry about DCFS involvement and their criminal charges. . . . This family has few supports. Both parents are unemployed and often in the home. Inappropriate boundaries, difficulties maintaining appropriate social connections and supports, and a lack of insight and empathy toward the needs of the children were evidenced. . . . There are few services available in [their town], requiring those living there to travel a distance for services. . . . At this time, the prognosis for reunification is poor.

Again, a parent's willingness to participate in treatment emerged as a key consideration in whether the prognosis for reunification was favorable. At the same time, the assessments brought together a complex set of individual, family (including extended family), and contextual challenges that these families were facing—challenges that would need to be addressed, perhaps aggressively, in order to sustain engagement in services and any progress that might be made through those services.

Reunification Outcomes and Subsequent Placements

The prognosis for reunification for the children in these families included many contingencies or conditional statements, and one would expect the actual reunification outcomes to reflect the complexities of individual and family functioning combined with uncertainties regarding service availability, quality, ongoing engagement, and effectiveness. For 170 of the 174 children in these 85 families, we were able to track placement discharge outcomes for 30 months after they entered foster care. There was no difference in the percentage of children who were reunified based on whether one of the parents reported 4 or more ACEs or not (30% vs. 35% ($X^2 = .47$, $df = 1$, $p = .49$)), and the average length of stay was over 300 days for both groups. However, among the roughly one-third of cases where a child was reunified, the rate of reentry into foster care was higher among those who had a parent with 4 or more ACEs than for those who did not have a parent with 4 or more ACEs (32% vs. 7%, $X^2 = 5.5$, $df = 1$, $p = .02$). While the percentages seem large, the numbers are small, so interpretation should be made cautiously. However, it is interesting to note that for the nine children who were initially returned to a parent with 4 or more ACEs but then reentered foster care, the average time between discharge and reentry was relatively short—46 days.

It is important to remember that the administrative data on reunification do not inform us about which parent the child was reunified with (e.g., mother or father, custodial or noncustodial), nor do the data provide any indication of the extent to which the reunification reflects changes in parents' behaviors. In

some of these cases, the safety issues that led to placement in foster care may have revolved around the ability of one parent to protect the child(ren) from potential harm presented by another parent or paramour. Compliance with services or changes in the household composition—and not necessarily evidence of cognitive or behavioral change—may be sufficient for determining that risk has been reduced and the child can return home. The reentry into foster care and, in particular, the short duration of that reunification attempt among children with a parent who reported a high ACEs score raises questions about the impact of these changes on the child’s well-being. We see in this subset of families the challenges of looking at and addressing these issues from a family perspective and the tensions between parental rights and child well-being.

Study Limitations

Before reviewing the findings from this study and engaging in a discussion of the policy and practice implications, it is important to impart a few cautionary notes. First, the data from which this sample was drawn are not necessarily representative of all families involved with the child welfare system in Illinois. DCFS initially decided to focus the IA program on the subset of children for whom the department makes an immediate decision of placement in foster care without first providing in-home services. This group of children, which is the focus of this study, represents approximately one-half of all Illinois children who enter foster care. That being said, the parents depicted in this paper who report 4 or more ACEs do represent a sizeable portion of those placement cases that are referred to the IA program. These parents may warrant special consideration with respect to assessment approaches, caseworker time, and treatment interventions, given that the investment needed for positive behavior change to occur may be greater than for other families.

Second, much of the data presented in this study is qualitative and was extracted from extensive narrative reports. The sample size is relatively large for a qualitative study and reasonable for bivariate comparisons, and the sampling approach bolsters the generalizability of the findings; however, the sample size is not sufficient for performing more complex quantitative models that would examine differences in outcomes while taking into account variability in the characteristics of the groups being compared. As such, the quantitative findings in this study should be interpreted with caution. They may, however, serve to inform decisions about data that might be collected for large-scale studies wishing to further explore these relationships.

Third, this study neither supports nor advances a conclusion that parents who were abused or neglected in their childhood will grow up to abuse or neglect their own children. Given that this is a sample of families

already involved with the child welfare system, it excludes those parents who experienced extensive childhood trauma but—perhaps as a result of protective factors, positive interventions, or system differences in reporting and detection—were never involved with the child welfare system as adults.

Discussion

This study provides an opportunity to understand how trauma-informed, comprehensive family assessments like those done in the Illinois IA program might facilitate the development of effective engagement strategies and interventions for a subset of parents in the child welfare system. Roughly one-third of parents in this study self-reported in the assessment process that they had experienced a significant number of traumatic events in their childhood, as indicated by parents' providing information that affirmatively matches more than four of the items on the ACEs questionnaire. The comprehensive assessments of these particular parents suggest that they have histories replete with childhood trauma; adolescence characterized by substance use, limited educational attainment, dysfunctional family paradigms, poor models for romantic relationships, a lack of stable employment, and compounded problems in their current functioning (e.g., mental health, substance abuse, domestic violence, etc.). The assessments described both the evolution and consequences of multiple adverse and traumatic experiences from childhood into adolescence and adulthood. These patterns of experiences are consistent with findings from prospective studies in which adults who experienced abuse and neglect in their childhood were found to be more likely to struggle with various health and mental health problems in adolescence and adulthood (Widom, DuMont, & Czaja, 2007; Weich, Patterson, Shaw, & Stewart-Brown, 2009).

Such findings have implications both for the parents and for their children. Research suggests that the chronicity of symptoms and treatment response may differ for adults who experienced early life stress and that children may be impacted by environmental effects of being raised by a parent who was abused as a child (Neigh, Ritschel, & Nemeroff, 2010). Given the risk of poor outcomes for the parent and the child, more targeted strategies are needed regarding engagement and treatment for this particular subgroup of parents. Those strategies will need to take into consideration the complex set of family and neighborhood challenges that these parents face. This is a subset of families whom the child welfare system likely

struggles to serve, and their experiences and outcomes should challenge us to think about the implications for child welfare policy and practice.

Implications for Parent Engagement in Child Welfare Systems

Over time, these parents' childhood experiences have shaped their day-to-day behaviors and their view of the world. However, every new interaction becomes another source of meaning and potential influence for change, and social workers have an opportunity to understand and begin to reshape the social experiences of these parents, to build on strengths, to facilitate social supports, and to provide them with additional concrete examples of positive parenting as well as a sense that positive changes are achievable and a plan for making those changes can be implemented (Berlin, 2003).

Cordon et al. (2004) point out that "traumatic events are often experiences that punctuate our life stories, perhaps becoming a part of who we are, marking turning points, closing options, and changing directions." It is this dynamic that child welfare caseworkers and treatment providers will need to engage with when working with parents in the child welfare system who have extensive trauma histories. The belief that the caseworker-client relationship serves as a primary catalyst for change is a fundamental underpinning of social work practice (Robinson, 1930; Perlman, 1979). That relationship, in turn, is believed to influence the extent to which the client accepts the conceptualization of the problems that need to be addressed and the likelihood that the client will engage with the change process (Horvath, 1995). Although these ideas hold true for all social work practice, they are especially pertinent in child welfare where both the parents' problems and the policies and authority of the child welfare system may create significant barriers to engagement. The relationships between these parents and their caseworkers are likely to be particularly challenging, and caseworkers will require good clinical supervision to balance their dual roles as change agents and representatives of the state's authority.

Implications for Intervention Design and Service Arrays

If caseworkers are successful in engaging parents with extensive histories of childhood trauma, they may still find it difficult to connect them with services and interventions that have been shown to be effective. According to an analysis of evidence-based programs conducted by the Washington State Institute for Public Policy, successful programs tend to be designed for a specific group of people who are expected to benefit from the services provided (Lee, Aos, & Miller, 2008). That level of specificity typically leads to the exclusion of those parents in child welfare who present with multiple problems. For example, some

home visiting programs focus on first-time mothers and some family preservation programs require substance abuse problems to be addressed first. Research on evidence-based medicine and psychosocial treatments often focus on narrow diagnostic categories and exclude comorbidity of conditions, rendering them to be a poor fit for the complexity of problems faced by children and families in the child welfare system (Barth, 2008). Thus, there is a paucity of information about how to design and deliver effective interventions to those child welfare families who struggle simultaneously with multiple individual, family, and contextual problems.

The lack of services available to parents involved with the child welfare system is also evident in the Child and Family Service Reviews (CFSR). Most of the 35 states participating in a CFSR in FY 2002–2004 had an insufficient array of services for parents, particularly with respect to substance abuse assessment and treatment services and mental health services (U.S. Department of Health and Human Services, 2004). Reunification was perceived to be limited by the availability of mental health and substance abuse services for parents, and reentries of children into care were attributed to the same services deficits (McCarthy, VanBuren, & Irvine, 2007). Studies have confirmed that unmet parental mental health needs, poverty, unemployment, and inadequate housing are associated with reentry into care (Loring, 1998; Miller, Fisher, Fetrow, & Jordan, 2006; Frame, Berrick, & Brodowski, 2000; Festinger, 1996); however, the extent to which the failure should be attributed to parents versus the child welfare and social service systems is less clear.

Implications for Child Welfare Policies

In light of the current emphasis on child well-being, the decisions regarding how to work with these parents cannot be separated from questions of how the parents' progress (or lack thereof) and the child welfare system decisions impact the children over time. Beliefs about whether people—including parents charged with maltreatment—can change their behaviors juxtaposed against evidence regarding the importance of stability and an environment that nurtures children's development has long created significant tension for policymakers, as evidenced in the congressional debates preceding the passage of the Adoption and Safe Families Act (ASFA) of 1997 (Barriers to Adoption, 1996).

In its efforts to balance parental rights and child well-being, ASFA provided guidance on reunification exceptions—or specific conditions that allow states to bypass the provision of reunification services—and timelines for permanency planning hearings (12 months) and filing a petition to terminate parent rights (for any child that has been in foster care for 15 out of the most recent 22 months). However, as D'Andre

and Duerr Berrick (2006) note, nothing in ASFA changed the capacities or opportunities for parents to reunify with their children, and the implementation of the reunification exception raises significant concerns about the inequitable application of the exception and the poor predictive value of prognosis indicators that might be used to guide reunification decisions.

The prioritization of reunification within our federal policies is reflected in the directive given to the Integrated Assessment screeners in this study that, unless contraindicated, the goal should be for the family to reunite. The concerns about having valid, reliable poor prognosis indicators are also evident in this study. Although the rate of foster care reentry was significantly higher among those children who were reunified and had a parent with 4 or more ACEs, it was not the majority. In fact, approximately two-thirds of the children reunified with a parent who had 4 or more ACEs did not reenter foster care during the timeframe for this study. Reunification and permanency are considered desirable goals for the child and for the child welfare system, yet permanency may not always be equated with child well-being.

We know that many children are struggling in their developmental and educational achievements at the time they are placed in foster care (Smithgall, Jarpe-Ratner, & Walker, 2010). Children who are safe and in stable living arrangements are better able to focus on learning and better able to successfully navigate challenges throughout their childhood. What are the implications, then, for children who experience changes in living arrangements and supportive relationships as a result of foster care experiences or being reunified with their parents? Perhaps more importantly, what steps might we take to minimize negative effects on the child while still promoting reunification of the family? A public health perspective on well-being for children in the child welfare system emphasizes prevention. As such, policymakers should consider opportunities to invest in providing children who have ever been involved with foster care with access to high-quality child care and educational programs that can support their development both during periods when the child welfare system is focusing on parents' progress toward reunification but also after reunification. Such access would simultaneously tend to the goals of improving reunification outcomes and improving child well-being.

Conclusion

Illinois DCFS's implementation of the Integrated Assessment program, in which caseworkers and licensed clinicians conduct trauma-informed, clinical assessments of families whose children enter foster care, has created an opportunity to understand better the developmental pathways of a subgroup of parents with extensive histories of childhood trauma. These parents are more apt to struggle in their current functioning, and their children's well-being may be impacted by the parents' behaviors and the child

welfare system's decisions. Although successful reunification with their children may depend on specialized interventions and engagement strategies for this subgroup of parents, there is a significant disconnect within the child welfare system between the availability of these strategies and services and the timeline within which reunification and permanency decisions need to be made. A family systems and child well-being perspective raises questions critical to shaping the future direction of child welfare systems: What constitutes reasonable efforts for parents with such extensive histories of trauma and problems in functioning? If parents' current functioning is believed to be reflective of their cumulative experiences, to what extent does the child welfare system have an ethical obligation to serve these families that extends beyond addressing the immediate safety issues? What does that obligation entail, and if we are going to focus on child well-being, then what are the implications of that for working with parents?

References

- Anda, R. F., Butchart, A., Felitti, V. J., & Brown, D. W. (2010). Building a framework for global surveillance of the public health implications of adverse childhood experiences. *American Journal of Preventive Medicine*, 39(1), 93–98.
- Anderson, R. L., & Huffine, C. (2003). Child & adolescent psychiatry: Use of community based services by rural adolescents with mental health and substance use disorders. *Psychiatric Services*, 54(10), 1339–1341.
- Barriers to adoption: Hearing before the Subcommittee on Human Resources of the Committee of Ways and Means, House of Representatives*, 104th Congress 1 (1996).
- Barth, R. (2008). The move to evidence based practice: How well does it fit child welfare services? *The Journal of Public Welfare*, 2(2), 145-171.
- Berlin, S. (2002). *Clinical social work practice: A cognitive integrative perspective*. New York, NY: Oxford University Press.
- Berlin, S., & Marsh, J. (1993). *Informing practice decisions*. New York, NY: Macmillan.
- Child Welfare League of America. (March 2002). Family reunification. *Research Roundup*. Washington, DC: Author.
- Cordon, I. M., Pipe, M., Sayfan, L., Melinder, A., & Goodman, G. S. (2004). Memory for traumatic experiences in early childhood. *Developmental Review*, 24, 101–132.
- Cook, A., Spinazzola, J., Ford, J., Lanktree, C., Blaustein, M., Cloitre, M., . . . Van der Kolk, B. (2005). Complex trauma in children and adolescents. *Psychiatric Annals*, 35(5), 390–398.

- Creswell, J. W., Plano Clark, V. L., Gutmann, M. L., & Hanson, W. E. (2003). Advanced mixed methods research designs. In A. Tashakkori & C. Teddlie (Eds.), *Handbook of mixed methods in social and behavioral research* (pp. 209–240). Thousand Oaks, CA: Sage.
- D’Andre, A., & Duerr Berrick, J. (2006). When policy meets practice: The untested effects of permanency reforms in child welfare. *Journal of Sociology and Social Welfare, 33*, 31–52.
- Dube, S. R., Miller, J. W., Brown, D. W., Giles, W. H., Felitti, V. J., Dong, M., & Anda, R. F. (2006). Adverse childhood experiences and the association with ever using alcohol and initiating alcohol use during adolescence. *Journal of Adolescent Health, 38*, 444.e1–444.e10.
- Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., . . . Marks, J. S. (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*, 245–258.
- Festinger, T. (1996). Going home and returning to foster care. *Children and Youth Services Review, 18*, 383–402.
- Frame, L., Berrick, J. D., & Brodowski, M.L. (2000). Understanding reentry to out-of-home care for reunified infants. *Child Welfare, 79*, 339–369.
- Gopalan, G., Goldstein, L., Klingenstein, K., Sicher, C., Blake, C., & McKay, M. M. (2010). Engaging families into child mental health treatment: Updates and special considerations. *Journal of the Canadian Academy of Child and Adolescent Psychiatry, 19*(3), 182–196.
- Griffin, G., & Studzinski, A. (2010). Child trauma as a lens for the public sector. (Illinois Childhood Trauma Coalition White Paper). Retrieved from <http://www.law.uchicago.edu/files/file/ICTC%20White%20Paper%20120110.pdf>
- Horvath, A. O. (1995). The therapeutic relationship: From transference to alliance. In J. D. Safran and J. C. Muran (Eds.). *The Therapeutic Alliance* (pp. 7–17). New York, NY: Wiley & Sons.
- Jones, L. (1998). The social and family correlates of successful reunification of children in foster care. *Children and Youth Services Review, 20*(4), 305–323.
- Kerkorian, D. L., McKay, M. M., & Bannon, W. M. (2006). Seeking help a second time: Parents’/caregivers’ characterizations of previous experiences with mental health services for their

- children and perceptions of barriers to future use. *American Journal of Orthopsychiatry* 76(2), 161-166.
- Lee, S., Aos, S., & Miller, M. (2008). *Evidence-based programs to prevent children from entering and remaining in the child welfare system: Benefits and costs for Washington*. Olympia, WA: Washington State Institute for Public Policy
- Littell, J., & Schuerman, J. (1995). *A synthesis of research on family preservation and family reunification programs*. Chicago: Westat, James Bell Associates, and the Chapin Hall Center for Children at the University of Chicago.
- Lyons, J. (2004). *Redressing the emperor: Improving our children's public mental health system*. Westport, CT: Praeger.
- Lyons, J. S., & Weiner, D. A. (2009). *Behavioral health care: Assessment, service planning, and total clinical outcomes management*. Kingston, NJ: Civic Research Institute.
- Maluccio, A. N., Fein, E., & Davis, I. P. (1994). Family reunification: Research findings, issues, and directions. *Child Welfare*, 73(5), 489–504.
- Marsh, J., Ryan, J. P., Choi, S., & Testa, M. (2006). Integrated services for families with multiple problems: Obstacles to family reunification. *Children and Youth Services Review*, 28, 1074–1087.
- McCarthy, J., Van Buren, E., & Irvine, M. (August 2007). *Child and family services reviews: 2001-2004: A mental health analysis*. Washington, DC: Georgetown University Center for Child and Human Development, National Technical Assistance Center for Children's Mental Health and the Technical Assistance Partnership for Child and Family Mental Health, American Institutes for Research.
- Miles, M. B., & Huberman, A. M. (1994). *Qualitative data analysis*. Newbury Park, CA: Sage.
- Miller, K. A., Fisher, P. A., Fetrow, B., & Jordan, K. (2006). Trouble on the journey home: Reunification failures in foster care. *Children and Youth Services Review*, 28, 260–274.
- Merkel-Holguin, L., Nixon, P., & Burford, G. (2003). Learning with families: A synopsis of FGDM research and evaluation in child welfare. *Protecting Children*, 18(1-2), 2–11.
- National Childhood Traumatic Stress Network. (2011). Birth parents with trauma histories and the child welfare system: A guide for child welfare staff. Retrieved from http://nctsn.org/sites/default/files/assets/pdfs/birth_parents_trauma_history_fact_sheet_final.pdf

- Neigh, G. N., Ritschel, L. A., & Nemeroff, C. B. (2010). Biological consequences and transgenerational impact of violence and abuse: Understanding the risks associated with early life stress. *Psychiatric Times*, 27(11), 1–7.
- Perlman, H. H. (1979). *Relationship: The heart of helping people*. Chicago: The University of Chicago Press.
- Perry, B. D. (2001). Bonding and attachment in maltreated children: Consequences of emotional neglect in childhood. Retrieved from http://www.childtrauma.org/images/stories/Articles/attcar4_03_v2_r.pdf.
- Prochaska, J. O. and DiClemente, C. C. (1984). *The transtheoretical approach: Crossing the traditional boundaries of therapy*. Melbourne, FL: Krieger Publishing Company.
- Putnam, F.W. (2006). The impact of trauma on child development. *Juvenile and Family Court Journal*, 57(1), 1-11.
- Robinson, V. (1930). *Changing psychology in social case work*. Chapel Hill, NC: The University of North Carolina Press.
- Schene, P. (2005). *Comprehensive family assessment guidelines for child welfare*. Retrieved from http://www.acf.hhs.gov/programs/cb/pubs/family_assessment/family_assessment.pdf
- Schwartz, A. E. (2004). Societal value and the funding of kinship care. *Social Service Review*, 76(3), 430-459.
- Smithgall, C., Jarpe-Ratner, E., & Walker, L. (2010). *Looking back, moving forward: Using integrated assessments to examine the educational experiences of children entering foster care*. Chicago: Chapin Hall at the University of Chicago.
- Sroufe, L. A. (1997). Psychopathology as an outcome of development. *Development and Psychopathology*, 9, 251–268.
- Testa, M. F., Shook, K. L., Cohen, L. S., & Woods, M. G. (1996). Permanency planning options for children in formal kinship care. *Child Welfare*, 75(5), 451–470.
- Thomlison, B., Maluccio, A. N., & Abramczyk, L. W. (1996). The theory, policy, and practice context of family reunification: An integrated research perspective. *Children and Youth Services Review*, 18(4-5), 473–488.

- Titcomb, A., & LeCroy, C. (2003). Evaluation of Arizona's family group decision making program. *Protecting Children, 18*(1-2), 58–64.
- U.S. Department of Health and Human Services, Administration for Children and Families. (2004). General findings from the federal child and family services review. Retrieved from: <http://www.acf.hhs.gov/programs/cb/cwmonitoring/results/genfindings04/>
- U.S. Department of Health and Human Services, Administration for Children and Families. (2009). Reasonable Efforts to Preserve or Reunify Families and Achieve Permanency for Children: Summary of State Laws. Retrieved from: http://www.childwelfare.gov/systemwide/laws_policies/statutes/reunifyall.pdf
- Van der Kolk, B. A., Roth, S., Pelcovitz, D., Sunday, S., & Spinazzola, J. (2005). Disorders of extreme stress: The empirical foundation of a complex adaptation to trauma. *Journal of Traumatic Stress, 18*(5), 389–399. Retrieved from http://www.traumacenter.org/products/pdf_files/SpecialIssueComplexTraumaOct2006JTS3.pdf
- Weich, S., Patterson, J., Shaw, R., & Stewart-Brown, S. (2009). Family relationships in childhood and common psychiatric disorders in later life: Systematic review of prospective studies. *The British Journal of Psychiatry, 194*, 392–398. doi: 10.1192/bjp.bp.107.042515
- Wheeler, C. E., & Johnson, S. (2003). Evaluating family group decision making: The Santa Clara example. *Protecting Children, 18*(1 & 2), 65–69.
- Widom, C. S., DuMont, K., & Czaja, S. J. (2007). A prospective investigation of major depressive disorder and comorbidity in abused and neglected children grown up. *Archives of General Psychiatry, 64*(1), 49–56.
- Wulczyn, F. (2004). Family reunification. *The Future of Children, 14*(1), 95–113.
- Wulczyn, F., Chen, L., & Hislop, K. B. (2007). *Foster care dynamics 2000-2005: A report from the Multistate Foster Care Data Archive*. Chicago: Chapin Hall Center for Children.
- Yeh, M., & Weisz, J. R. (2001). Why are we here at the clinic? Parent-child (dis)agreement on referral problems at outpatient treatment entry. *Journal of Consulting & Clinical Psychology, 69*(6), 1018–1025.

About Chapin Hall

Established in 1985, Chapin Hall is an independent policy research center whose mission is to build knowledge that improves policies and programs for children and youth, families, and their communities.

Chapin Hall's areas of research include child maltreatment prevention, child welfare systems and foster care, youth justice, schools and their connections with social services and community organizations, early childhood initiatives, community change initiatives, workforce development, out-of-school time initiatives, economic supports for families, and child well-being indicators.

