U.S. Department of Health and Human Services
Assistant Secretary for Planning and Evaluation

A Partial Listing of Problems Facing American Children, Youth and Families

August 1989

Office of the Assistant Secretary for Planning and Evaluation

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This report was prepared under contract between HHS's Office of Social Services Policy (now the Office of Disability, Aging and Long-Term Care Policy) and SysteMetrics/McGraw-Hill. For additional information about this subject, you can visit the ASPE home page at http://aspe.hhs.gov. The Project Officer was Ann Segal.

A PARTIAL LISTING OF PROBLEMS FACING AMERICAN CHILDREN, YOUTH AND FAMILIES

SysteMetrics/McGraw-Hill

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Prepared for
Office of the Assistant Secretary for Planning and Evaluation
U.S. Department of Health and Human Services

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INTRODUCTION

Overview

This collection of brief issue papers describes 15 major problem areas facing American children and families and summarizes the state of knowledge about the scope of the problems, trends, current government program expenditures, costs per case, the effectiveness of current intervention strategies and public attitudes about the problem areas. These papers are not intended to be comprehensive reviews of the current knowledge about the problems (which could fill volumes for some of the areas), but are broad brush attempts to encapsulate policy-useful information about problems and solutions in a consistent and integrative fashion. In some cases, vast areas of knowledge have been greatly summarized and, in others, there is little readily available data. One useful product of this effort is to highlight key information gaps.

This review focuses primarily on social and health service needs and programs affecting children and their families. Topics include:

- Child health (including infant mortality, children without health care coverage, pediatric/adolescent AIDS and mental health problems);
- Adolescents in trouble (including adolescent pregnancy, substance abuse, runaway youth, and educational/employment deficits);
- Child welfare services (including child abuse/neglect; adequacy of foster care services; and adequacy of adoption services);
- Lack of child care;
- Lack of early childhood education;
- Lack of child support; and
- Homelessness.

ASPE contracted with SysteMetrics/McGraw-Hill to develop these issue papers. ASPE staff determined the problems areas which would be included in the review and approved the outline to be followed for each issue paper. It was beyond the scope of the review to focus on the enormous problem areas of child/family poverty and general education. There are other sound reviews of these areas available (e.g., Ellwood, 1988; Committee on Ways and Means, 1985; Committee for Economic Development, 1985). Nonetheless, it is clearly apparent that the boundaries of problems and solutions described here are profoundly shaped by the income and educational resources and opportunities available to the nation's children and families.

Classes of Problems and Solutions

At an abstract level, the problems which children and families face can be divided into three basic categories:

- Problems which threaten lives,
- Problems which create severe social harm, which, while not necessarily life-threatening, hurt children and endanger their health or welfare in serious and unacceptable ways, and
- Problems which endanger economic productivity, which impair the ability of children to become productive members of society or which cause current unnecessary social costs.

These are all important types of problems, but they vary in terms of the immediacy and severity of their impacts. While categories were not mutually exclusive, most problems tended to fit primarily in one category, as shown in Exhibit 1. The major areas of overlap occurred for problems causing mental or psychological stress for children which, on the basis of research, appear to carry over into adult years with related social problems (e.g., lower incomes, family distress, etc.). As emphasized in the Adolescents in Trouble paper, these problems are not independent. Many are interrelated and often cluster among certain groups, such as low-income minority children living in inner cities.

EXHIBIT 1. Categories of Social and Health Problems Affecting American Children, Youth and Families

Problems Which Can Threaten Lives
- Infant/child mortality
- Pediatric/adolescent AIDS
- Child abuse (some)
- Substance abuse (direct and indirect through violence)

Problems Which Can Create Severe Social Harm
- Adolescent pregnancy
- Substance abuse
- Child abuse/neglect
- Homelessness
- Mental health problems
- Adequacy of foster care services
- Adequacy of adoption services
- Children without health care coverage
- Runaway youth

Problems Which Can Endanger Productivity
- Educational/employment deficits
- Lack of early childhood education
- Lack of child support
- Lack of child care
- Adolescent pregnancy
- Substance abuse

Solutions have two general categories:

- Preventive interventions, which try to identify and resolve problems at an early stage before they have more serious consequences, and

- Treatment services, which try to resolve or treat problems which have already occurred.

Again, there is no clear line between these two in some cases. For example, while child welfare services may find children who have already been abused or neglected, they seek to provide counseling to help tie current circumstances and also strive to prevent future incidents. It would be better to prevent problems before they occur, if possible. It is socially desirable to avoid the pain or harm inherent in these problems, and prevention efforts are often less expensive than remedial actions. However, often prevention is not possible because we lack effective preventive strategies, because we lack the ability to identify potential problems, or because prevention may cause other problems, such as high societal intrusion into family life and privacy. Thus, treatment services are the primary tools of most public programs. Clearly, future efforts must focus more on developing and implementing better problem identification and prevention programs.

Size of Problems, Current Service Rendered and Costs

Exhibit 2 summarizes selected data from each of the issue papers regarding number of people needing services; the number of people currently receiving services; current government expenditures per year; and cost per case. The definitions and data sources differ a little for each problem and are discussed in more depth in each of the attached issue papers. The numbers and costs are not completely comparable because of definitional discrepancies which are not readily resolved. However, they indicate the approximate size of the problem and costs which are involved in each type of problem. Data presented are usually based on statistics for relatively recent years (e.g., 1986 to 1988). When older data are used, these are noted. The issue papers also provide, where data are available, rough estimates of the cost to close the gap, i.e., to provide services to those currently unserved. These estimates are quite rough, since in many cases data are lacking or weak. Further, no specific attempt was made to outline specific proposals for serving the unserved. The estimates show the rough magnitude of costs for new services, but should not be considered definitive estimates of specific proposals.

Ranked on the basis of the size of the population potentially needing services, the largest problems are adolescent pregnancy and substance abuse, since virtually all children or adolescents are appropriate targets for prevention efforts. Compensatory education needs are next, based on size. A few million children lack adequate child support, early childhood education, health insurance and mental health services. However, size is certainly not the only indicator of need. Although relatively few children or adolescents have AIDS, the fatal nature of HIV infection makes it a major problem. Similarly, the number of women lacking any or adequate prenatal care is not extremely high, but the seriousness of infant mortality is obvious.

EXHIBIT 2. Selected Data by Problem Areas			
	Need/Service Population	**Expenditures Per Year**	**Cost Per Case**
Infant Mortality	Unmet Need: 220,000 mothers with little or no prenatal care Served: About 5.1 million AFDC-related adults receive Medicaid services annually; data are not available on the proportion who receive obstetrical care	$1.5 billion Medicaid for maternity/infant services (1985)	$500/mother for prenatal care $2,100-2,760 for delivery/ mother
Children Without Health Care Coverage	Unmet Need: 12.2 million children without health coverage Served: 10.2 million child recipients under Medicaid	$6.6 billion Medicaid for services to children	$521-$707/yr/child
Pediatric/ Adolescent AIDS	Need: 3,000 CDC/AIDS and 10,000-20,000 HIV-infected children <13 yrs. by 1991; 7,000 CDC/AIDS adolescents by 1991 Served: About 1,736 CDC/AIDS children <13 yrs.; 850 CDC/AIDS adolescents	$16 million-NIH research for children with AIDS Medicaid data not available for services to AIDS children	$100,000 lifetime costs/ person ($40,000/yr); children may be more expensive
Mental Health Problems	Need: 7.5-9.5 million children Served: <4 million children	Not available	Not available
Adolescent Pregnancy	Need/Prevention: 16.8 million 10-14 yr. olds; 9.4 million sexually active 15-19 yr. olds Need/Services: 1 million pregnancies/yr. to teenagers Served: Not available	Not available	Prevention: $10/ teen/ education $75-125/yr/ teen contraception Services: $2,650-4,000/ pregnant teen and teen parents
Substance Abuse	Need/Prevention: All teenagers Need/Services: Not available Served: 173,479 adolescents received treatment (1982)	Not available for children	$3,075/teen for drug treatment
Runaway Youth	Need: 1.2-1.5 million/children/yr. Served: 340,000 children in shelters	$26.1 million	Not available
Education/ Employment Deficits	Need: 2 million unemployed teens; 9.8 million teens need compensatory education	$4.4 billion-compensatory education $718 million-Summer Youth $716 million-Job Corps	$5,100/yr/teen in Job Corps $750/teen in compensatory education
Child Abuse/ Neglect	Need: 1.9 million children reported, with 795,000 actually substantiated (1985) Served: Not available	$500 million-Title XX (1985) $222 million-Title IVB $25 million-NCCAN $27 million-Children's Trust <$1 billion total nationwide	$2,860/yr/family for lay therapy to $28,000/ yr/family for comprehensive therapeutic services
Adequacy of Foster Care Services	Need: Not available Served: 375,000 children	See expenditure data under Abuse/Neglect	$2,135/yr/child
Lack of Child Care	Unmet Need: 600,000 low-income mothers Served: 1.7 low-income women (1982)	$6.9 billion	$1,652/yr/family Full time center: $2,500-7,000/ yr/child

EXHIBIT 2 (*continued*)			
	Need/Service Population	**Expenditures Per Year**	**Cost Per Case**
Lack of Early Childhood Education	Need: 2.7 million low-income children ages 3-5; about 900,000 low-income 4 yr. olds Served: 454,000 children enrolled in Head Start, of which 268,000 were low-income 4 yr. olds.	$1.23 billion by Head Start	$2,664/yr/child for Head Start
Lack of Child Support	Need: 14.8 million children in female-headed families; of these, 8.8 million children received awards, 5.4 million received some support, and 3.5 million received full support Served: 10.6 million cases served under IV-D, but cases not equivalent to children	$745 million Federal $315 million State $1.06 billion total	$100 yr/per case/all cases $588 yr/per case/cases with collection
Homeless Families and Children	Need: 68,000 children <16 yrs. per night; 9,000 sleeping in public places Served: 25,000 urban shelters, 21,800 in suburban/rural area shelters, 4,000 in churches	$1.5 billion total, on all shelters nationwide (not just shelters for families) includes Federal, State, local and private expenditures	$29/night/person
Unless noted, all data are for 1986 or later. However, data from 1986 to present have not been adjusted to any one year. Expenditure estimates are for Federal dollars only, except for Medicaid which is a jointly financed Federal-State program, or when otherwise noted.			

It is difficult to assess the economic consequences of these childhood problems fairly, but our rough impression is that problems most endangering the future productivity of our children are adolescent pregnancy, educational/employment deficits and substance abuse. These create current societal costs, such as welfare payments or the costs of crimes which may be promoted by drug abuse or idleness, as well as deterring education or employment opportunities needed to get good jobs and lifestyles in adult years. Given the demographic trends associated with the maturing of the Baby Boomers and future labor shortages, it is more necessary than ever that we have a well-trained and able cohort of future workers and leaders for the nation.

The review of public attitudes was incomplete since only a few of the areas have been brought up in recent public opinion surveys, but there is strong evidence that in 1989 Americans view drugs as the biggest domestic problem (Morin, 1989). Efforts to reduce drug use appear to have strong public support. However, there also appears to be substantial support for enhanced government roles to help American children and families.

Current Knowledge About Potential Solutions

From a policy perspective, the most important question is what can we do to better address these problems? Billions of dollars are being spent and many thousands of people are working in programs to help children. Unfortunately, for most of these

areas, there is inadequate evaluation of program interventions. In some cases, there is no clear agreement on what constitutes a successful intervention. The issue papers attempt to digest the most relevant information on the effectiveness of intervention strategies, where it exists. The gaps in the knowledge and the diversity of intervention approaches necessitate subjective assessments of the apparent effectiveness of potential interventions. Generally, the papers present what would be a consensus view within the given discipline.

In four problem areas, there seem to be highly effective strategies which already exist which could be implemented or enlarged across the nation. However, implementation of some efforts would be so expensive that they could only be considered in the light of significant trade-offs with other areas of public spending policy. These areas include infant mortality, children without health care coverage, child care and early childhood education:

- Prenatal and postnatal medical care and nutrition are considered relatively effective methods of preventing low birthweight, decreasing infant mortality and avoiding high neonatal intensive care costs.

- The Head Start Program has been demonstrated to have substantial short-term effects on children's mental performance and health. Other high quality pre-school programs have resulted in long-term improved outcomes for low-income children.

- There is little doubt that, in principle, the nation has the capability to provide good quality health insurance and child care for those currently lacking services, especially the low-income. However, the costs for such services would be quite high and it is less clear how much these interventions would reduce underlying problems of poor child health, low family income or welfare dependency.

In six areas, there appears to be evidence of moderate effectiveness of strategies currently available. The grave nature of the problems and the lack of more effective interventions indicates the need for reinvigorated demonstration projects and social research to develop better tools. These six areas are pediatric/adolescent AIDS, adolescent pregnancy, educational/employment deficits, child abuse/neglect, child support and homelessness:

- There is some encouraging evidence of increasing condom use and acceptance of other strategies to prevent AIDS, but it is unclear how well prevention is reaching hard-core groups, such as mothers using IV drugs or whose partners are using them, who are prime causes of pediatric AIDS.

- Educational services appear to improve rates of contraception use, which should deter adolescent pregnancy. Some programs providing health and social support services to pregnant and parenting teens appear to reduce bad consequences of adolescent pregnancy.

- Evaluations of child abuse treatment programs have generally indicated serious limitations, such as high reincidence rates. However, prevention programs, especially those aimed at new parents, show promising results in improved outcomes.

- Studies indicate that compensatory education is associated with improved school achievement. Some youth employment programs appear to improve employability and wage rates for the enrollees.

- Research indicates that strong child support programs are associated with enhanced child support payment patterns. Some evidence suggests that guidelines on setting child support awards increases the award levels. The Family Support Act of 1988 made changes to improve child support enforcement.

- In principle, most areas have the capability to provide shelter for homeless families and children. However, the mixed quality of the shelter provided and the inability to prevent homelessness indicates the need to develop better programs.

In some areas, there is little evidence of interventions generally viewed as successful. It is not completely clear whether this indicates that programs are not efficacious, whether evaluation research has not been conducted or whether desired outcomes are not well-defined. These areas may require development of better solutions, more evaluation research or both. These include mental health, substance abuse, runaway youth, and foster care:

- Many children appear to receive inappropriate mental health care. The efficacy of general mental health services is not clear, although it probably varies by diagnostic category.

- There has been minimal evaluation of adolescent drug treatment programs. Evaluations of prevention programs have generally been disappointing, although some comprehensive social influence programs appear to have modest positive effects on drug use behaviors. Data from the survey of high school seniors suggests that adolescent drug use may be declining, except for cocaine.

- Strong evaluations related to runaway youth and foster care programs were not identified.

Conclusion

The overall assessment of this report is that the nation faces a wide array of serious problems involving American families and children. While substantial efforts and expenditures are already being made to address these problems, there are still very large gaps in services. Public opinion polls tend to indicate that, not only is the

American public concerned about social problems like these, the public is generally supportive of increased spending to reduce these problems.

In a number of areas current approaches to prevention or treatment are not as effective as might be hoped, given the scope of the problems. In conjunction with the maintenance of current program efforts, interventions in these areas need further development and research, such as well-conceived and executed demonstration projects. In general, the government can play an important role in developing and fostering better prevention programs in most of these problem areas. Prevention is usually both more humane and more economical.

There is a growing consensus, however, that current interventions for other problems are relatively effective (Schorr, 1988). In these areas, the Federal government, in concert with State and local governments and the private and non-profit sectors, has the ability to improve the lives of American children, youth and families.

References

Committee for Economic Development, Research and Policy Committee. Investing in our Children. New York: Committee for Economic Development, 1985.

Committee on Ways and Means. Children in Poverty. Washington, D.C.: Government Printing Office, 1985.

Ellwood, David. Poor Supports Poverty in the American Family. New York: Basic Books, 1988.

Morin, R. "Drug Abuse Leads the Nation's Worries," Washington Post. August 22, 1989.

Schorr, Lisbeth (with Daniel Schorr). Within Our Grasps Breaking the Cycle of Disadvantage. New York: Doubleday, 1988.

CHILD HEALTH PROBLEMS

1. Definition of the Problem Area

While there are many areas of concern with regard to the health care needs of children, this summary will focus on four problem areas: infant and child mortality, lack of child health care coverage, pediatric/adolescent AIDS and the mental health problems of children. Three areas relevant to child health are discussed in other sections: child abuse and neglect, adolescent pregnancy, and substance abuse.

Infant and Child Mortality

2. Trends

In 1988, the U.S. reported an infant mortality rate of 9.9 infants per 1,000 live births, or about 40,000 infants. As a point of comparison, Japan's infant mortality rate was 5.5 for 1985. Also of importance, the black infant mortality rate in 1986 was 18.0, compared to 8.9 for whites. Although the U.S. infant mortality rate has generally been decreasing (the infant mortality rate was 12.6 in 1980), the rate of decline has slowed (Office of Technology Assessment, 1988). The U.S. Surgeon General has established as a public health goal the reduction of the rate to 9.0 infant deaths per 1,000 live births by 1990; however, it is not clear whether this objective will be met.

The slowing decline in infant mortality rates is primarily attributable to two factors: changes in birth reporting (increased reporting of births as live that in the past would have been reported as fetal deaths or would have been unreported), and an increased ability to resuscitate very tiny newborns (although these newborns die very shortly) (Office of Technology Assessment, 1988). The leading causes of infant death are congenital anomalies, sudden infant death syndrome, respiratory distress syndrome and disorders relating toshort gestation and low birthweight (Hughes, Johnson, Rosenbaum and Liu, 1989).

Generally, mortality rates have been decreasing for children of all ages. However, several patterns are of concern. First, except for ages 15-19, mortality rates are greater among black children than white children. Second, mortality rates are still quite high for all children ages 15-19. Low income is also associated with higher mortality rates for children (Office of Technology Assessment, 1988).

Injury is the leading cause of death among children above 9 months of age. Injuries cause about 44% of all deaths in children age 1-4, 51% for ages 5-9, and 58% for ages 10-14. Motor vehicle accidents account for the largest proportion of death (including bicycles and pedestrians), followed by drowning and house fires. Injury death rates for children generally declined from 1980 to 1985, with two exceptions--homicide

and juvenile suicide. Between 1980 and 1985, the rate of teen suicide doubled (Waller, Baker and Szocka, 1989).

It is also important to note that the U.S. falls behind other developed countries in child mortality rates, in addition to the infant mortality rate. A higher rate of injuries and violence accounts for this, not death from natural causes. In 1985, the U.S. child death rates for injuries were one and one half to two times as high as in 5 European countries and about one and one half times greater than those in Canada, Japan and Australia (American Public Health Association, 1989).

3. Number of Children and Families in Need/Service Population

The most important preventive service to combat infant mortality is adequate prenatal care for mothers. Children born to mothers who do not receive prenatal care are three times more likely to die in infancy. In 1986, about 220,000 infants were born to mothers who received late prenatal care or no prenatal care at all. This represented about 6% of births. Among all age groups of mothers, teenagers are the least likely to receive adequate prenatal care. The majority of women not receiving prenatal care are low-income and uninsured (Hughes, Johnson, Rosenbaum and Liu, 1989).

The Medicare Catastrophic Coverage Act of 1988 mandated that all States extend Medicaid coverage to pregnant women with income up to 75% of the poverty level by July 1, 1989 and 100% by July 1, 1990. In addition, States have the option of going to 185% of the poverty level for Medicaid coverage of pregnant women. To date, only 9 States have opted to extend their coverage of pregnant women to the maximum allowable, with another 4 States between 100-185%. Data are not available to confirm whether Medicaid's expanded coverage provisions are making a significant difference in increasing the number of women receiving adequate prenatal care (Hughes, Johnson, Rosenbaum and Liu, 1989). In FY1986, about 5.1 million AFDC-related adults received Medicaid services, but data are not available on the number of women receiving obstetrical care under Medicaid (Congressional Research Service, 1988).

The leading cause of child mortality after the first few months of life is accidental injuries. In 1984, 7,850 children under age 15,died of such injuries. Rivara lists 12 preventive interventions which could significantly reduce childhood injury-related deaths:

- infant seat restraints in cars,
- air bags for front seat car occupants,
- helmets for motorcycles,
- helmets for bicycles,
- expansion and enforcement of the Poison Prevention Package Act,
- barriers around swimming pools,
- self-extinguishing cigarettes,
- smoke detectors,
- elimination of handguns,

- knowledge of the Heimlich maneuver,
- adherence to Consumer Product Safety Commission regulations, and
- window bars in windows above first floor (Office of Technology Assessment, 1988).

4. Expenditures

Medicaid is the major source of Federal funding for prenatal care and delivery. In 1985, Medicaid provided an estimated $1.5 billion for these services, $2 billion when neonatal intensive care is included. Federal funding for Maternal and Child Health programs in 1987 was $497 million. However, combined Federal and State funding for MCH services declined in constant dollars by 23.5% between 1981 and 1984 (Office of Technology Assessment, 1988). The recent Medicaid expansions may be able to compensate for some of this decline in funding in health care for low-income pregnant women.

Data are not readily available on Federal/State expenditures targeted to combating child deaths.

5. Costs per Child

The costs of prenatal care to Medicaid were estimated in 1983 to be about $500 per mother, including both physician and ancillary services. Delivery charges were an additional $2100 to $2700 (Howell, 1989). The Office of Technology Assessment estimated the costs per mother for prenatal care at $380 in 1986. However, this estimate only covered physician services and did not include laboratory, x-ray and other services often involved in prenatal care (Office of Technology Assessment, 1988).

6. Cost to Address Unmet Service Need

We have estimated that 220,000 women are in need of prenatal care. At an average cost of $500 (Medicaid data) per mother to cover prenatal care, the cost of extending prenatal services to all uncovered women would be about $110 million annually, if implemented immediately. Numerous studies have shown the cost-effectiveness of prenatal care. The Institute of Medicine has estimated that each $1 spent on prenatal care will save up to $11 over a child's lifetime (Hughes, Johnson, Rosenbaum and Liu, 1989). Similarly, the Office of Technology Assessment has indicated that the costs to Medicaid of expanding coverage of pregnant women would be totally offset by the savings which would result (Office of Technology Assessment, 1988). Conservatively assuming a 50% cost savings in the same year, a $55 million cost is estimated.

The Children's Defense Fund has estimated that expanding Medicaid to cover all pregnant women with family incomes less than 200% of poverty would run about $1 billion a year, when fully implemented. However, this estimate appears to take into account the costs of delivery and post-natal care. Presumably, the delivery charges

(probably at least half this total) would not be additional costs to the health care system, since these costs are already being absorbed as bad debt, uncompensated care or Medicaid charges (Hughes, Johnson, Rosenbaum and Liu). Assuming that half the costs are already being met, new funding of roughly $500 million would close the gap.

7. Effectiveness of Intervention

The literature on reducing infant mortality cites numerous studies on the effectiveness of prenatal services in improving birth outcomes (Office of Technology Assessment, 1988; and Hughes, Johnson, Rosenbaum and Liu, 1989).

Interventions for reducing child mortality rates due to accidental injuries are more difficult to assess, particularly in terms of cost-effectiveness. Where feasible, automatic protection is the most effective intervention. This strategy includes measures such as automatic seatbelts and airbags in automobiles and barriers over windows. Interventions which require people to change their behaviors are considered less effective. These interventions include educating children (and their parents) about the importance of wearing safety belts in automobiles and wearing helmets when bicycling. Some programs which actually require behavioral change may be more effective. These strategies include such regulatory approaches as requiring child restraints in automobiles, the installation of smoke detectors in homes, and fences around swimming pools (Office of Technology Assessment, 1988).

8. Public Opinion

See discussion under Children without Health Care coverage.

Children Without Health Care Coverage

2. Trends

In 1986 about 12.2 million children, or 20% of all children, were reported to be without any health insurance coverage. This number does not include children on Medicaid. Among children in low-income families, 36% or 5.0 million children, were without health care coverage. Children in low-income working families were the group hardest hit, since many of them are ineligible for Medicaid, and employers in low-wage jobs are less likely to provide health insurance coverage. Children in poor, single-parent families were the most likely to be uninsured, especially if that parent was a full-year worker. About 53% of children in this group were uninsured in 1986. For children in poor two-parent families with a full-time worker, 43% of children were uninsured (Chollet, 1986). This pattern is exacerbated for black children. About 70% of white children in employed families had health insurance coverage, compared to only 49% of black children (Hughes, Johnson, Rosenbaum and Liu, 1989).

There are also problems with underinsurance, even for those children who are supposedly covered. Many private employer plans do not cover routine preventive services for children. Many plans have high deductibles and coinsurance which restrict access. Finally, many plans have service or dollar limits.

CPS data suggest that the health insurance coverage of children is getting worse instead of better. In 1986, the CPS reported that 19% of children under age 13 were uninsured, compared to 17% in 1980 (Office of Technology Assessment, 1988). Most analysts attribute this increase to shifting employment patterns (more jobs in small businesses without health coverage) and the higher cost of insurance (causing many employers to drop coverage or pass more of the cost on to employees, making it unaffordable for some) (Butler, 1988).

A final trend of importance relates to Medicaid coverage of poor children. In 1978, there were about 984 Medicaid recipients under age 18 per 1,000 children in poverty. By 1985, this ratio had decreased to 813 per 1,000 children. Two factors account for Medicaid's eroding coverage of children. First, AFDC income eligibility levels have declined in real terms, thus making it more difficult many poor children to qualify for Medicaid. Second, an increasing proportion of poor children are in two-parent families, a group for which Medicaid eligibility is optional and therefore not uniform across States (Rymer and Burwell, 1987). However, Federally-mandated expansions in Medicaid coverage of low-income children since 1984 may work to reverse this trend.

3. Number of Children and Families in Need/Service Population

In 1986, 12.2 million children were estimated to be without health insurance coverage. This number includes some 300,000 disabled children. About 5 million of these children live in low-income families. The Medicaid program has been the primary strategy for extending health care coverage to poor children. In the last five years, numerous mandatory and optional coverage provisions have been legislated to expand Medicaid's coverage of children, especially infants and very young children. All States are required to extend Medicaid coverage to infants whose family income is less than 75% of the poverty level by July 1, 1989, with an increase to 100% by July 1, 1990. Thirteen States have opted to go up to 185% of the poverty level for infant coverage. About 30 States cover children up to age 8 with family incomes below the poverty level, while another 6 States cover children of all ages below the poverty level.

In FY1986, about 10.2 children received services under Medicaid (Congressional Research Service, 1988). As with the Medicaid expansions related to pregnant women, data are not yet available to assess whether the number of low-income children covered by Medicaid has significantly increased as a result of recent Congressional initiatives.

4. Expenditures

In 1987, the Medicaid program spent $6.6 billion on children (excluding disabled children). Medicaid is the main source of Federal/State financing for low-income

children without health care coverage. Data are not available on Medicaid expenditures for disabled children.

5. Costs per Case

The Medicaid program provides the best numbers for estimating the cost of providing health care financing to uncovered children. In 1986, Medicaid spent about $521 annually for each AFDC child who utilized any services during the year. For children not receiving cash assistance (medically needy children), this amount was $707 per child recipient (Congressional Research Service, 1988). These averages would be lower if the children who were enrolled, but did not use any services during the year, were included.

6. Cost to Address Unmet Service Need

We have estimated that 12.2 million children are without health insurance coverage. If we use the Medicaid annual cost of $521 per AFDC child recipient and assume that about 80% of children would use some services during the year, the per child annual cost would be about $415. This yields an estimate of just over $5 billion for expanding Medicaid to all children without health insurance coverage. If only the 5 million children living below the poverty level who do not have health care coverage were included, the expansion costs would be just over $2 billion. These numbers may overstate the costs, however, since Medicaid in recent years has significantly expanded its coverage of children. Recently the Children's Defense Fund estimated the cost of expanding Medicaid to cover all children under 200% of the poverty level to be only $750 million to $1 billion when fully implemented.

7. Effectiveness of Intervention

Discussion not necessary for this problem.

8. Public Opinion

Numerous polls have shown widespread public support for child health programs. A June 1988 poll by Peter Hart Associates reported that 78% of American voters felt that "early childhood health programs need more attention and resources under the next President" (Hart, 1988). In a Gallup poll, taken about the same time, 51% of U.S. adults favored government action to "provide adequate-medical care for all who need it but can't afford it even if new taxes are needed" to pay for the program (Gallup, 1998). More recently, 61% of respondents to a Washington Post-ABC poll conducted in August 1989 favored increased federal spending for Medicaid, which provides free health care to the poor" (Morin, 1989).

Pediatric and Adolescent AIDS

2. Trends

The Center for Disease Control (CDC) defines children with pediatric AIDS as children with Acquired Immunodeficiency Syndrome (AIDS) or AIDS Related Complex (ARC) from birth to 13 years of age. Through July 1989, 1,736 children with pediatric AIDS had been reported to CDC (CDC, 1989). The vast majority of these children were (82%) under 5 years of age at diagnosis. Most contracted AIDS before or during birth from HIV-infected parents. The parents who transmit AIDS to their children are predominantly IV drug users or partners of IV drug users. About 53% of pediatric AIDS cases were black, 24% Hispanic and 23% white. Most were reported to live in poor, inner-city areas .

It is important to note that the CDC estimates do not include all children with HIV-infection. Some children who test positive for HIV infection and who have symptoms of the illness do not meet CDC criteria for AIDS. Data from localities with large numbers of children with AIDS report from 2 to 4 times more children with HIV infection than the number of children meeting CDC AIDS criteria (Margolis, Baughman, Flynt and Kotler, 1988).

CDC estimates that there will be 10,000 to 20,000 HIV-infected children under 13 years of age by 1991, with about 3,000 meeting the official CDC definition. In 1987, the prevalence of HIV infection among newborns was 0.2% in Massachusetts and 0.8% in New York. Some sections of New York City reported a prevalence rate of 3% for newborns in 1987.

By September 1988, about 850 cases of AIDS among adolescents aged 13-21 were reported to CDC. Regional and local studies suggest this number is doubling every year (Select Committee for Children, Youth and Families, 1988 (b)). Among these cases, about 50% were reported to be homosexual or bisexual males, 12% intravenous drug users, 9% heterosexuals, with the balance including those infected by blood products or other modes of transmission. However, merely reporting the number of adolescents with full-blown AIDS understates the problem of AIDS for adolescents. Because of the long delay from infection to diagnosis of AIDS (7-8 years on average), many persons with AIDS reported among the age group over age 21 were infected during their teenage years.

(Unless otherwise cited, data in this section were taken from Hughes, Johnson, Rosenbaum, and Liu, 1989.)

3. Number of Children and Families in Need/Service Population

There are two groups in need of services related to pediatric and adolescent AIDS: children with the disease who need treatment and children and adults who need to be educated about the disease to prevent its spread. The number of children

requiring treatment is escalating daily, as reported earlier. The CDC estimates there will be 10,000 to 20,000 HIV-infected children under age 13 by 1991. As of July 1989, about 1,736 children with AIDS had been reported to CDC. The most recent data on adolescents with AIDS is for September 1988, at which time 85.0 cases had been reported to CDC. Presumably, all these children received services.

Until recently, hospital-based care has been the only placement available for some infants--so-called "boarder babies." In many instances, the parents cannot help because they also are infected, they are drug-addicted, they lack necessary supportive services, or they have abandoned their children. A New Jersey program has reported that 40% of the children with AIDS are under State protective services. Efforts are underway in many States to develop specialized foster care programs, respite care or other community-based services for children with AIDS (Select Committee on Children, Youth and Families, 1988(b)).

Many target groups are in need of preventive services. Drug abusers are expected to account for the largest increase in AIDS infection. This group accounts for 70% of perinatally transmitted AIDS cases. Currently, treatment reaches only about 12% of the estimated 1.2-1.3 million intravenous drug abusers in the United States (Select Committee on Children, Youth and Fami ies, 1988(b)). Services can range from methadone maintenance to preventive education to residential treatment programs.

Education is a critical preventive service. AIDS education in public schools has been mandated in only about half of the States. The President's Advisory Commission on HIV Infection recommended "age appropriate, comprehensive health education programs in our nation's schools, in kindergarten through grade twelve."

A target group for education involves sexually active adolescents. In 1982, about 64% of boys and 44% of girls were reported to be sexually active by age 18. The proportion of sexually active teenagers is higher among low-income and minority groups (Hayes, 1987).

4. Expenditures

$16 million of the Administration's FY1988 request for AIDS research at NIH was targeted specifically for children. For FY1987, $6.5 million was made available by CDC for school health prevention efforts (Select Committee on Children, Youth and Families, 1988(a)).

HCFA estimates that Medicaid expenditures for AIDS will reach $2.4 billion by 1992, compared to an estimated $940 million for FY 1989. HCFA estimates that nationally 40% of all patients with AIDS are served under Medicaid (Roper, 1987). No separate estimates on Medicaid expenditures for children with AIDS are available.

5. Cost Per Child

California officials reported in 1988 the costs of treating pediatric AIDS children to be about $6,375 monthly in a hospital setting (under Medicaid reimbursement, compared to $1,700-$2,000 monthly for specialized foster care per child (Select Committee on Children, Youth and Families, 1988 (b)). The Presidential Commission on AIDS estimated that the lifetime hospital costs for a person with AIDS was about $100,000, with annual treatment costs at approximately $40,000 (Presidential Commission on the Human Immunodeficiency Virus Epidemic, 1988). The California data suggest that the costs of treating children with AIDS may be higher.

6. Cost to Address Unmet Service Need

Based on estimates reported in an earlier section, it seems reasonable to assume that 3,000 children under age 13 with a positive diagnosis of AIDS or ARC (not just HIV-positive), will require services by 1991. At $100,000 per case, pediatric AIDS costs will then reach $300 million cumulatively, with most of these children expected to be dependent on Medicaid. However, this estimate does not include the cost of services to children with HIV-infection who do not meet CDC's definition. Data are not available on the cost per case for this latter group of children.

If the number of adolescents with AIDS doubles annually, by 1991, the total will have reached almost 7,000. This would imply cumulative expenditures of about $700 million to provide lifetime health care services for them.

Data were not available to estimate the costs of providing adequate services to educate children and adults about AIDS prevention.

7. Effectiveness of Intervention

The Institute of Medicine/National Academy of Sciences recently reported that the expansion of drug treatment programs is a cost effective strategy for reducing IV drug use and thus reducing the spread of AIDS. The Office of Technology Assessment reported that "although education on AIDS and sexuality appears to increase adolescent knowledge, there is little evidence that youth translate such knowledge into changes in their risk behaviors" (Select Committee on Children, Youth and Families, 1988 (b)).

Mental Health Problems of Children

2. Trends

From 12-15% of children under 18 years of age (7.5 to 9.5 million children) are reported to have mental health problems severe enough to require treatment (Office of Technology Assessment, 1986). The most commonly cited disorders are depression,

conduct disorders, eating disorders, attention deficit disorders/hyperactivity, autism, psychosis and suicide (Select Committee on Children, Youth and Families, 1988(a)).

The number of suicides among teenagers has been increasing. The suicide rate of teenagers has doubled since 1960. This increase has mainly occurred among white males. In 1984, about 1,900 teenagers committed suicide, for a rate of 10.9 per 100,000 teenagers (National Association of Children's Hospitals and Related Institutions, 1989).

An estimated 70-80% of emotionally disturbed children get inappropriate mental health services or no services at all (Office of Technology Assessment, 1986).

3. Number of Children in Need/Service Population

The Office of Technology Assessment estimated that the majority of the 7.5 to 9.5 million children in 1986 who had mental health problems either got inappropriate mental health services or no services at all. Often, the lack of services is a coverage problem since most private and public health insurance plans (including Medicaid) offer very limited mental health services or none at all. In addition, shortages exist in all forms of child mental health care, particularly community-based care, case management and coordination across educational, judicial and other child serving agencies (Office of Technology Assessment, 1986).

4. Expenditures

In FY 1987, about $248 million went to mental health services under the Alcohol, Drug Abuse and Mental Health Block Grant to States. It is not known what portion of these monies go to mental health services for children. However, in 1985 GAO survey found that some States chose not to fund children's services at all with the block grant money. In FY 1985, about $50 million was spent on children and youth-related services by NIMH. This represents about 21% of total NIMH expenditures. The federal Child and Adolescent Service System Program spent $4.7 million in FY 1986 to help states and localities develop better systems of care for emotionally disturbed children and adolescents (Select Committee on Children, Youth and Families, 1988(a)). Data are not available on Medicaid expenditures for child mental health problems.

5. Cost Per Child

Data were not available on the cost per child of providing mental health services.

6. Cost to Address Unmet Service Need

Data were not available to calculate the overall costs of providing services to children not receiving mental health services or those receiving inappropriate mental health services.

7. Effectiveness of Intervention

Data were not readily available on the effectiveness of mental health services for children, although as cited above, the Office of Technology Assessment has reported that many children in need of services often receive inappropriate care.

References

Butler, Patricia. Too Poor To Be Sick. American Public Health Association, 1988.

Centers for Disease Control. The HIV/AIDS Surveillance Report. August, 1989.

Chollet, Deborah. "Uninsured in the United States: The Nonelderly Population without Health Insurance, 1986." Employee Benefit Research Institute, 1988.

Congressional Research Service. Medicaid Source Book: Background Data and Analysis. Washington, D.C.: U.S. Government Printing Office, November, 1988.

Hayes, Cheryl, Editor. Risking the Future: Adolescent Sexuality, Pregnancy, and Childbearing. National Academy Press, 1987.

Howell, Embry and Brown, Gretchen. "Medicaid Financing of Obstetrical Care in Three States in 1983." Paper to be published in Health Care Financing Review in near future.

Hughes, Dana; Johnson, Kay; Rosenbaum, Sara; and Liu, Joseph. The Health of America's Children. Children's Defense Fund, 1989.

Margolis, Stephen; Baughman, Lela; Flynt, J.W.; and Kotler, Martin. AIDS Children and Child Welfare. Macro Systems, Inc., 1989. [http://aspe.hhs.gov/daltcp/reports/aidskids.htm]

Miller, C. Arden. "Maternal Health and Infant Survival." National Center for Clinical Infant Programs, 1987.

National Association of Children's Hospitals and Related Institutions. Profile of Child Health in the United States, 1989.

Newacheck, Paul W.; Budetti, Peter; and Halfon, Neal. "Trends in Activity-limiting Chronic Conditions among Children." American Journal of Public Health, Vol. 76, No. 2, February, 1986.

Roper, William. "From the Health Care Financing Administration," Journal of the American Medical Association, Vol. 258, No. 24, 1987.

Rymer, Marilyn and Burwell, Brian. Medicaid Eligibility: Analysis of Trends and Special Population Groups. Health Care Financing Administration Medicaid Program Evaluation Working Paper 5.6, 1987.

Select Committee on Children, Youth and Families. "Report on the Activities for the Year 1987." Washington, D.C.: U.S. Government Printing Office, 1988(a).

Select Committee on Children, Youth and Families. "Continuing Jeopardy: Children and AIDS." Washington, D.C.: U.S. Government Printing Office, 1988(b).

U.S. Congress, Office of Technology Assessment. Healthy Children: Investing in the Future. OTA-H-345. Washington, D.C.: U.S. Government Printing Office, February 1988.

Waller, Anna; Baker, Susan; and Szocka, Andrew. "Childhood Injury Deaths: National Analysis and Geographic Variations." American Journal of Public Health, Vol. 79, No. 3, March, 1989.

ADOLESCENTS IN TROUBLE

1. Definition of the Problem Area

This summary focuses on four problem areas that affect U.S. teenagers: Adolescent Pregnancy, Substance Abuse, Runaway Youth and Educational/ Employment Deficits. Although each of these problems is discussed separately, these problems are actually highly correlated. As a result, the newest recommended prevention strategies are early intervention programs that comprehensively attempt to prevent what is now seen as a syndrome of problems. Although treatment programs for these problems once they occur remain highly specialized, programs oriented to preventing these problems among adolescents often combine multiple interventions like health education and promotion, academic skills building, job training and career/life planning to intervene simultaneously on all problem fronts.

While the number of teenagers grew during the 1960's and early 1970's, peaking in 1976, they have steadily declined since then. In 1986, there were approximately 22 million youth between the ages of 14-19 years, and they made up 9 percent of the total population (U.S. Department of Education, 1988). The decline in the youth population is expected to continue into the 1990's. The demographic shift has important implications for our future society and economy. Labor shortages may be a problem in the near future.

Adolescent Pregnancy

2. Trends

Teenage pregnancy is now recognized as one of the most widespread and costly problems plaguing American youth today. Each year approximately one million young women in the U.S. become pregnant and just over half a million bear children. These figures mean that approximately 11 percent of women between the ages of 15-19 annually experience a pregnancy, close to half (44%) become pregnant at least once during their teens, and one-fifth become mothers. Among black women the rates of pregnancy are 50 percent higher and the rates of childbearing are double. The United States has twice the adolescent pregnancy rate of other developed nations like Canada, Great Britain, France, Sweden or the Netherlands.

Bearing a child during adolescence is extremely costly for the young woman and her child. Young mothers and their babies disproportionately experience life threatening and expensive health problems. Educational attainment and job prospects suffer. Poverty and welfare dependency are likely, and even more likely, if the birth occurs out-of-wedlock (Hayes, 1987). One-third of all teenage mothers receive AFDC (Weder, n.d.) and it has been estimated that two-thirds of teenage mothers receive AFDC at some

time during the 10 years following the birth (Wertheimer and Moore, 1982). In 1985, families started by teenage mothers cost the nation an estimated $16.5 billion in AFDC, Food Stamps and Medicaid benefits; over half of these expenses were borne by the Federal government (Burt, 1986), with the balance paid by State and local governments.

Over the 1970's the number of adolescent pregnancies increased and the pregnancy rate rose from 9.4 percent in 1972 to 10.5 percent in 1978. Since the late 1970's the declining adolescent population resulted in a fall in the number of teen pregnancies, but the teen pregnancy rate continued to climb to a high of 11.1 percent among young women in 1980 and 1981. Since then the rates have stabilized between 10.9 and 11.0 percent. The most recent calculate pregnancy rate is 10.98 percent of women ages 15-19 in 1985 (Child Trends, 1989).

The abortion rate among teenagers increased over the 1970's and has remained level in the 1980's. The abortion rate among young women ages 15-19 was an estimated 4.4 percent in 1985 and the number of abortions was 399,200 (Child Trends, 1989).

The birthrate among teenagers declined in the 1970's and has fluctuated around 5 percent in the 19801s; it was 5.1 percent among 15-19 year old women in 1985. In 1986 472,000 births occurred to young women under the age of 20 (Child Trends, 1989).

Rates of pregnancy, birth and abortion are all substantially higher for non-white than for white teens. Child bearing among unmarried teens has risen. The proportion of teen births occurring outside of marriage has quadrupled since 1960, from 15 percent to 61 percent with most of this rise occurring among white teen births (Child Trends, 1989).

3. Number of Children and Families in Need/Service Population

Teenagers in need of assistance can be divided into those who need prevention programs and those who need supportive services once they are pregnant and parenting.

All teenagers are potentially at risk of initiating sexual activity which may result in unintended pregnancies. In 1988, the following proportions of U.S. teenagers were estimated to be sexually experienced:

Age	Males		Females	
	Whites	Blacks	Whites	Blacks
15	26%	69%	29%	26%
16	47%	70%	32%	46%
17	59%	90%	46%	69%
18	71%	83%	67%	69%
19	85%	96%	81%	81%
(Sources: Sonenstein, Pleck and Ku, 1989; London, Mosher, Pratt and Williams, 1989)				

Prevention programs aimed at promoting the postponement of sexual activity and the promotion of safe sex need to reach children and adolescents before they initiate sexual intercourse. The above data indicate programs should certainly start in the early teen years, before age 15 and provide reinforcement afterwards. Population projections indicate that in 1990 there will be 16.8 million 10-14 year old adolescents in the U.S. (Hayes, 1987).

Once teenagers become sexually active, effective contraception is the most efficacious means to reduce the incidence of teenage pregnancy. In 1990 an estimated 5.2 million males 15-19 and an estimated 4.2 million females ages 15-19 will be sexually active. Some teens will be effective contraceptors, but the majority will not and will therefore be in need of prevention services.

In 1986, there were approximately 472,000 births to teenage females under age 20. Approximately 293,000 were births to 18 and 19 year old women, 169,000 were to 15-17 year olds, and 10,000 were to girls under the age of 15. While some of the women over the age of 18 may need supportive services, the 179,000 young mothers under the age of 18 are appropriate to target as a population in need of services.

4. Expenditures

The last decade has seen the emergence of public recognition that adolescent pregnancy is a social problem needing remedy. Programs have been developed to assist teens once they are pregnant to avoid the many negative consequences of an early birth. A second focus has been on preventing these pregnancies in the first place.

Around the country programs that provide a range of health, education, and employment services to pregnant and parenting teenagers have been developed under the aegis of schools, hospitals, health departments, and even welfare departments. Funding has been provided by States, national and local foundations, United Ways and the Federal government. In these programs the most prominent Federal role has probably come through Medicaid reimbursement for necessary health services.

The Federal Office of Adolescent Pregnancy was established to coordinate the Federal role and to provide funding for comprehensive service models for pregnant and parenting teens. It provides grant funds to demonstration programs all over the country

under the auspices of the Adolescent Family Life legislation. (The Family Support Administration of DHHS and the Department of Labor have also recently funded demonstration programs for pregnant and parenting teens.)

The Federal role in prevention programs has been primarily through the Office of Adolescent Pregnancy which funds prevention programs aimed at reducing levels of sexual activity among teens and the Office of Family Planning which funds for contraceptive services for teens as well as older women under Title X ($140 million in FY 88). Other popular local prevention programs include school-based health clinics (funded by foundations, health and education departments) and sex education/AIDS programs in schools which have increased dramatically since 1982 (funded by education and health departments).

5. Costs Per Child

The cost for sex and family life education to prevent adolescent pregnancies is estimated at about $10 annually per child (based on data from the State of Illinois). The cost for contraceptive services is estimated at $75 annually per patient at a family planning clinic and at $125 annually per student in a school-based clinic (includes a range of other health services). The cost for comprehensive care programs for pregnant and parenting teens is estimated to range from $2,650 - $4,000 (in 1983 dollars) per program participant (Hayes, 1987).

6. Costs to Address Unmet Service Need

The overall cost of providing sex/family life education for 10-14 year old adolescents is estimated at $168 million ($10 x 16.8 million). About $315 million is estimated as the cost required to provide contraceptive services for sexually active 15-19 year old girls ($75 x 4.2 million). Meeting the need for comprehensive care programs for pregnant and parenting mothers (under 18) and their babies is estimated at $716 million ($4,000 x 179,000).

The gross cost of $1.2 billion presupposes that none of these services are currently covered. The estimate needs to factor out the numbers of teenagers who are already in sex education programs, contraceptive services and comprehensive care programs. Roughly assuming that about half of the need is already met through existing programs, private health insurance, etc., a net cost of $600 million is estimated.

7. Effectiveness of Intervention

The evidence about primary prevention programs oriented to postponing sexual activity among teenagers has been very poor because of weak evaluation designs. The only program that has shown some impact on teens delaying sexual activity is a Baltimore program which set up a storefront clinic nearby a junior and senior high school to provide contraception in the clinic in addition to providing educational programs in the schools.

The evidence about the effects of sex education are mixed. Teens who have had sex education report higher rates of contraception than other teens; however, it is unclear whether sex education has any impact on sexual activity rates. The National Academy of Sciences, after reviewing all the available research evidence, concluded that the "most effective intervention for reducing early unintended pregnancy in sexually active teenagers is diligent contraceptive use (Hayes, 1987)." A number of communities have developed "life option" prevention programs that combine sex education and contraceptive services with job training, career preparation, dropout prevention and educational enrichment. Evaluation results are not yet available.

Programs providing comprehensive health and social support services to pregnant and parenting teens report lower incidence of costly health problems at the time of the baby's birth. The evidence from 2 year followups on program participants has not been as conclusive about the impact of these programs on mother's educational status, welfare dependency and subsequent pregnancies. However, new evidence from one such demonstration program, Project Redirection, suggests that 5 years after program participation the mothers were working more hours, had higher average weekly earnings, and lower rates of AFDC participation than a comparison group of mothers. The children of former Project Redirection participants scored better on vocabulary tests, problem behavior scales and had more stimulating home environments (Polit, 1988).

8. Public Opinion

When adolescents are asked to name the "biggest problem facing teenagers", teen pregnancy is the third most frequent problem cited (after drug and alcohol abuse). In 1987 over 10 percent said it was a leading problem. Among young women this rose to almost one in five and among black teens to almost one in four. In contrast, a 1985 survey only found 3 percent of teens thought it was a major problem. In this same survey, a quarter of teens reported at least some peer pressure to have sex (Bezilla, 1988).

Youth are aware of the seriousness of teen pregnancy and motherhood. In the 1987 wave of the National Survey of Children, 70 to 85 percent of 18 to 22 year olds agreed that "becoming an unmarried mother is one of the worst things that could happen to a 16 year old girl." Almost as many agreed that being an unmarried father was "one of the worst things that could happen to a 16 year old boy." (Moore and Stief, 1989).

Substance Abuse

2. Trends

The most prevalent drugs used by young people are, in decreasing order, alcohol, tobacco, marijuana, stimulants, sedatives and tranquilizers, cocaine, hallucinogens and inhalants, and heroin. According to a 1986 national survey of high school seniors, nearly 60 percent reported that they had tried an illicit drug; more than two-thirds had used cigarettes, and 91 percent had used alcohol (Falco, 1988).

From the mid-1960's until 1980 adolescent drug use rose sharply. Since 1980 the reported use of controlled substances, except cocaine, among adolescents has declined; but the levels of use are still very high. The 1986 survey of high school seniors found the reported incidence of drug use in the previous 30 days to be as follows:

Alcohol	64%	Marijuana	18%
Stimulants	5%	Cocaine	3%
LSD	2%	PCP/Psychedelic	0.3%
Heroin	0.2%		
(Source: Child Trends, 1989)			

A further source of concern is that since 1980, first-time drug use appears to be occurring at younger ages. The percentage of students using drugs by the 6th grade has tripled in the last 10 years (Falco, 1988). A 1987 nationwide survey of eighth grade students found that three-quarters had used alcohol--with more than one-quarter saying that they had had 5 or more drinks at one sitting during the preceding two-week period. Five percent of the eighth graders reported using marijuana in the preceding month (Otten, 1989).

Cocaine and crack use among teenagers is increasingly problematic. The use of cocaine among high school seniors rose to 7 percent in 1985 and appears to have dropped to 3 percent in 1988. But the daily use of cocaine has doubled and more seniors report difficulties in stopping cocaine use. The recent emergence of crack, a powerful form of smokeable cocaine, is a major health threat among adolescents because it is packaged and sold in units that are affordable for most teenagers. Because of lag time in data collection, national surveys do not yet provide an accurate picture of crack use, but most recent surveys show a substantial increase in the proportion of adolescents who have smoked cocaine (Falco, 1988). Recently, there has been awareness of a new problem--infants born to drug users. Drug-exposed infants exhibit a wide range of physical and developmental difficulties.

Federal efforts to deal with the drug problem consist of supply control efforts--law enforcement and legal restrictions on availability--and demand side reduction efforts involving prevention, education and treatment. Between 1980 and 1986 the major emphasis of Federal drug policy has been on restricting the supply of drugs. Funding for

drug law enforcement has increased by more than $700 million while Federal support for drug abuse services declined approximately 40 percent (Falco, 1988; U.S. House of Representatives, Select Committee on Children, Youth and Families, 1988). Despite the law enforcement efforts, supplies of illicit drugs have continued to grow, while treatment programs have not.

The Anti-Drug Abuse Act passed in October, 1986 provides $1.7 billion in new money for law enforcement, treatment, prevention, education, and international narcotic control efforts. The Act broke down previous bureaucratic barriers which separated alcohol, tobacco and drug prevention efforts. The newly created Office of Substance Abuse Prevention within the Alcohol, Drug Abuse and Mental Health Administration will focus on substances regardless of their legal status, particularly those which pose the greatest risk to young people--alcohol, tobacco, marijuana and cocaine (Falco, 1988).

3. Number of Children and Families in Need/Service Population

Treatment for compulsive drug/alcohol use is needed by approximately 5 to 15 percent of the teenagers who experiment with drugs and alcohol. In 1986 the Drug Abuse Warning Network which reports hospital emergency room admissions reported that there were 13,343 drug abuse episodes involving adolescents ages 10-17 and 7,393 episodes involving young people ages 18 and 19.

Very little is known about the population of young people in treatment. The last available nationwide figures are for 1981 when 12 percent of the total treatment population was under 18.

Very little work has been done on developing treatment programs specifically designed for adolescent drug and alcohol abusers. In 1982 only 5 percent of the 3,000 substance abuse facilities surveyed by the National Institutes of Drug Abuse (NIDA) and Alcoholism and Alcohol Abuse (NIAAA) served predominantly adolescent populations. The majority of adolescents in treatment are in programs like drop-in centers, clinics which provide psychotherapy and family therapy, and activity programs like stress challenge experiences and camping. The next largest group of adolescents receive treatment in residential programs. In recent years there has been a rapid growth of private residential adolescent treatment programs operated by for-profit corporations which are not supported by public funds (Falco, 1988).

4. Expenditures

In 1985 annual appropriations of Federal funds for drug law enforcement were $1.65 billion. Drug prevention and treatment programs received $400 million in Federal dollars. Although current information is not available about non-Federal expenditures in treatment programs, in 1982 Federal expenditures made up 24 percent of the total expenditures and the remaining 76 percent came from State governments (31 percent), local governments (8 percent), health insurance (20 percent), client fees (10 percent) and other sources (8 percent) (Polich, Ellickson, Reuter and Kahan, 1984).

The 1986 Anti-Drug Abuse Act provides $3 billion for law enforcement and $930 million for treatment, education and prevention (Falco, 1988).

5. Costs Per Child

In 1982, $533.6 million was spent serving 173,479 clients at an average cost of $3,075 per client (Polich et al., 1984).

6. Costs to Address Unmet Service Need

Estimates not available.

7. Effectiveness of Intervention

There is little systematic data on the effectiveness of adolescent drug treatment programs. The few studies that have been done suffer from the absence of comparison groups. These studies have found that adolescent clinics do little to reduce marijuana and alcohol use although other positive outcomes occur like reduction in criminal activities and opiate use. Evaluation research on residential programs had shown a high correlation between length of treatment and reduced alcohol and drug use (Falco, 1988).

Evaluations of drug education programs which have focused on increasing knowledge levels or fostering stronger self images have found little evidence of impact on drug taking behaviors. The most recent approach to prevention, and the most promising, are "social influence" programs which increase students' awareness of social and peer pressures to experiment with substances and which teach them specific techniques to resist these pressures. Some preliminary evaluations of smoking prevention programs based on this model show significant impacts (Falco, 1988). A recent comprehensive school/community drug prevention project has been considered relatively successful and was associated with decreased alcohol, marijuana, and tobacco use (Pentz, et al., 1989).

8. Public Opinion

Drugs and efforts to combat drug use are among the most visible news stories in recent months. Newspapers have given front page coverage to shocking stories of female crack users trading sex for drugs, giving birth to addict babies, and abusing their children. In 1987, two thirds of New York child abuse fatalities were drug-related (Besharov, 1989). The public sees drug use at the nexus of related problems of violent crime, health and mental health problems, child abuse, and AIDS.

National polls indicate that public concern about combatting drug abuse exceeds worry about nuclear war (Falco, 1988). Public concern about the drug problem has reached record levels: in August 1989, 44 percent felt drugs were the nation's biggest

problem. As of two years ago, less than 10 percent would have ranked drugs as the number one problem (Morin, 1989). Even adolescents are aware of the problem: a 1988 poll found 60 percent of adolescents ranking drugs as the number one problem, with alcohol abuse ranking number two (Bezilla, 1988).

The public is willing to spend money to fight drugs. As of 1989, 76 percent of those polled favored increased federal spending on the "Federal anti-drug program" and half wanted funding for drug programs increased (Morin, 1989). Other surveys have repeatedly shown public support for increased government efforts to combat drug abuse, even if this meant more spending (Gallup Poll, 1988).

Runaway Youth

2. Trends

There are indications that runaways are increasingly young people with serious problems. The National Network of Runaway and Youth Services, an organization of approximately 1,000 community based youth-serving agencies, reported that in 1985 60 percent of the 300 shelter programs served had seen higher proportions of youth with multiple problems than before. Almost half the youths had experienced abuse or neglect, needed specialized treatment, or had been involved with the juvenile justice system. Federally funded shelters report that between 1978 and 1985, the number of youth with serious problems (serious emotional disturbances, drug abuse, school dropouts) rose as well as the number of youths who had been in the care of other human service systems like foster care, mental health or juvenile justice facilities (Children's Defense Fund, 1988).

While many runaway youth return home within a short period of time, a growing proportion cannot. In FY 1987 approximately 53 percent of the youths in Federally funded shelters returned home, 37 percent went into other stable situations--relatives, friends, foster care, group homes or independent living programs, and 10 percent had no designated destination. These youth are especially vulnerable to crime, prostitution, drug abuse and HIV transmission.

The Runaway Youth Act was enacted in 1974 as Title III of the Juvenile Justice and Delinquency Prevention Act. In 1980 the Act was expanded to address the needs of homeless youth as well. Funding has increased from $11 million in FY 1982 to $26 million in FY 1987. This funding provides assistance to local communities for centers which provide shelter and counseling to runaway youth. In addition, it funds the National Runaway Switchboard, which has operated for the last 10 years (Children's Defense Fund, 1988).

3. Number of Children and Families in Need/Service Population

Approximately 1.2 million to 1.5 million children and adolescents ages 10-17 run away from home each year in the United States, not including the many others who run away from foster care or residential placements (Children's Defense Fund 1988). Statistics are not available about the numbers of these children and adolescents who are provided assistance. In FY 1987 Federally funded centers reported serving 340,000 youth; 85,000 received shelter and ongoing services, and 255,000 more were served on a drop-in basis. Shelters are reported to turn way many youth because no space is available. Many other youth have no place to go when they leave shelters. It has been estimated that shelters nationwide serve only about one-fifth of those needing services. Most shelters have limited beds and can house youths for no longer than 2 weeks (Children's Defense Fund, 1988).

4. Expenditures

In FY 1987 the Federal government appropriated $23.2 million for runaway youth; in FY 1988 the appropriation was $26.1 million. In addition to Federal funds, an unknown amount of State, local and private funds supported programs for runaway youth (Children's Defense Fund, 1988).

5. Costs Per Child

In FY 1987 $23.2 million was used to serve 340,000 youths at an average cost of $68 per person. Costs to provide services beyond simple shelter would be substantially more.

6. Cost to Address Unmet Service Need

For various reasons, it seems likely that a large number of runaway youth would not enter shelter programs even if they were available. Assuming that about half of runaway youth might use shelters and that 20 percent are now using them, a net $39 million in increased shelter funding would provide additional services needed at the current cost per year. Some of these costs might be absorbed into other programs, such as those for homelessness or child abuse.

7. Effectiveness of Intervention

Evaluations of runaway youth programs do not appear to have been conducted.

Educational/Employment Deficits

2. Trends

Over the past three decades, teenagers in the U.S. have experienced remarkable educational gains. In 1960, 39 percent of 25-29 year olds had not completed high school; but by 1986 the proportion had fallen to 14 percent. The gains have been even more remarkable for the non-white population. While 61 percent of 25-29 year old non-whites in 1960 had not completed high school, the proportion was 16 percent in 1986 (U.S. Department of Education, 1988).

Young adults are completing more years of education; however, the proportion completing college has not changed significantly since 1975. Also, while school drop-out rates have fallen, the rates remain high in concentrated areas with large poverty populations. In the city of Boston, for example, the odds that a sophomore in public schools will complete high school are 50 percent.

As education levels have risen, so has the importance of education in ensuring earnings capacity. Overall, the real incomes of young male workers have fallen between 1973 and 1986, but young men with the least education have experienced the greatest drops. Between 1973 and 1986 the mean annual income of a male high school dropout age 20-24 fell 26 percent from $11,939 to $8,859 (in 1985 dollars). The mean annual income of male college graduates only fell by 6 percent from $14,357 to $13,502 (in 1985 dollars) and the mean annual income of black college graduates actually rose by 16 percent (Sum and Fogg cited in William T. Grant Foundation Commission on Work, Family and Citizenship, 1988).

In this same period 1973 to 1984 the proportion of young men, especially black young men, without incomes and earnings has grown significantly. In 1973 only 7.3 percent of young men ages 20-24 reported no earnings, and by 1984 the proportion had risen to 12 percent. This rise is not the result of college students failing to seek employment, it is the failure of young men with limited education to obtain any employment. Among black dropouts 14 percent had no earnings in 1973 compared to 43 percent in 1984 (Berlin and Sum, 1988). Across racial groups, 1 in 4 high school dropouts is unemployed.

On virtually every major standardized test, minorities and the poor are concentrated in the bottom fifth of the test score distribution. On average, black and Hispanic scores are 70 percent of white scores. Although the gap has closed markedly over the past few years, it remains large. Children with basic skill deficiencies are 9 times more likely to drop out of school, 8 times more likely to have an out-of-wedlock birth, and 4 times more likely to become welfare dependent--holding constant the effects of sex, race and family income (Berlin and Sum, 1988).

Although State and local government are the primary payors for education, the Federal government has provided leadership in funding compensatory education. Title I

of the Elementary and Secondary Education Act of 1965 was the Federal government's first major effort to provide compensatory education services to educationally disadvantaged and low income students to keep them from falling behind their more advantaged peers. In 1981 the program was substantially revised and became Chapter 1 of the Education Consolidation and Improvement Act, under which the program is currently authorized (U.S. House of Representatives, Select Committee on Children, Youth and Families, 1988). Federal funding for compensatory education under Chapter 1 fell by $200 million in inflation adjusted dollars between 1981 and 1988. In 1980 Chapter 1 served 75 percent of all poor children; by 1985 this proportion had fallen to 54 percent (Children's Defense Fund, 1988).

During the past two decades the Federal government has made several efforts to increase employment and earnings prospects for youth. Between the 1960's and the early 1980's Federal outlays on youth employment services were mostly for work experience programs. The Comprehensive Employment and Training Act of 1974 (CETA) provided funds to State and local governments for employment and training services. Under CETA the largest youth programs were the Youth Employment and Training Program (YETP), the Summer Youth Employment Program, and the Youth Community Conservation Improvement Program. The Job Training Partnership Act of 1983 replaced CETA as the Federal government's major employment and training program for disadvantaged youth. Two Federal programs--the Job Corps and the Summer Youth Employment Program--have remained intact since the 1960's. In recent years, the policy thrust of the Federal government has been to provide leadership in calling for excellence in education.

3. Number of Children and Families in Need/Service Population

In 1988, between 750,000-950,000 or 25 percent of U.S. high school students left public school without graduating. In 1987, 700,000 students graduated but were as deficient in basic skills and work habits as most dropouts (U.S. House of Representatives, Select Committee on Children, Youth and Families, 1988).

In 1985, 4.9 million students--about 50 percent of those estimated to be in need--received compensatory education services. Approximately 14 percent of all students from kindergarten to the 8th grade are enrolled in Chapter 1 compensatory education programs (U.S. House of Representatives, Select Committee on Children, Youth and Families, 1988).

In 1986, 2.1 million youth ages 16-21 were unemployed. Approximately 1.1 million youth participated in the Job Corps, JTPA Title IIA programs or Summer Youth Programs (U.S. House of Representatives, Select Committee on Children, Youth and Families, 1988).

4. Expenditures

In FY 1988 the Federal government spent $4.4 billion on compensatory education programs, $147 million on bilingual education, $5.5 billion on student financial assistance (college and university), $2.6 billion on guaranteed student loans (college and university) and $206 million on services for disadvantaged first generation college students (the TRIO program).

In the same year the JTPA program was funded at $3.4 billion with $718 million for the Summer Youth program and $716 for the Jobs Corps.

5. Costs Per Child

Compensatory education costs average about $750 per year per child. Job Corps costs average about $5,100 per participant (1977).

6. Costs to Address Unmet Service Need

Not estimated.

7. Effectiveness of Intervention

Studies of the effects of compensatory education show statistically significant gains in reading and mathematics over a year, narrowing of achievement gap between black and other elementary students and improvement in achievement as a result of substantial parent involvement (U.S. House of Representatives, Select Committee on Children, Youth and Families, 1988).

Evaluations of youth employment and training programs show that when the programs combine remedial education, training and well-structured work experience, improvements in employability and wages result. Interventions have been successful in helping students to remain in school and have reduced slimmer learning loss.

8. Public Opinion

President Bush struck a responsive chord with the public when he announced that he wanted to be the "Education President." Americans are very concerned about the quality of education and the importance of building good skills and opportunities for American youth. These are perceived as vital and necessary investments in our future. In recent years, the importance of this has penetrated even the business community. The corporate sector has begun to show interest in upgrading the skills of its future work force. Faced with a shrinking number of youth entering the labor pool, many companies have joined a campaign to improve education (preschool through post-secondary) opportunities for children and adolescents at risk of educational and employment deficits (Committee for Economic Development, 1985).

References

Berlin, Gordon and Sum, Andrew. Toward a More Perfect Union: Basic Skills, Poor Families and Our Economic Future. New York: Ford Foundation, 1988.

Bezilla, Robert. America's Youth: 1977-1988. Princeton, NJ: The Gallup Organization, 1988.

Burt, Martha, with Frank Levy. "Estimates of Public Costs for Teenage Childbearing," in Risking the Future Vol. 2 (ed) Sandra Hofferth and Cheryl Hayes. Washington, D.C.: National Academy Press, 1987.

Child Trends. Draft Tables. May 5, 1989.

Children's Defense Fund. A Children's Defense Budget FY 1989. Washington, D.C., 1988.

Committee for Economic Development, Investing in Our Children, New York: Committee for Economic Development, 1985.

Falco, Mathea. "Preventing Abuse of Drugs, Alcohol, and Tobacco by Adolescents." Carnegie Council on Adolescent Development Working Papers, June, 1988.

Gallup Poll. The People, The Press and Politics: Times Mirror Survey III. Princeton, NJ: The Gallup Organization, June 1988.

Hayes, C.D. Risking the Future: Adolescent Sexuality, Pregnancy and Childbearing. Washington, D.C.: National Academy Press, 1987.

Jessor, R. and Jessor, S.L. Problem Behavior and Psychosocial Development: A Longitudinal Study of Youth. New York: Academic Press, 1977.

London, K.A.; Mosher, W.D.; Pratt, W.F.; and Williams, L.B. "Preliminary Findings from the National Survey of Family Growth, Cycle IV." Data presented at the Population Association of America Annual Meeting, March, 1989.

Moore, Kristin and Steiff, Thomas. "Changes in Marriage and Fertility Behavior: Behavior Versus Attitudes of Young Adults." Washington, D.C.: Child Trends, July 1988. [http://aspe.hhs.gov/daltcp/reports/marfet.htm]

Morin, R. "Drug Abuse Leads Nation's Worries," The Washington Post. August 23, 1989.

Otten, Alan L. "Surveying Teenagers on Health and Behavior," The Wall Street Journal. May 22, 1989.

Polich, J. Michael; Ellickson, Phyllis; Reuter, Peter; and Kahan, James P. Strategies for Controlling Adolescent Drug Use. Santa Monica, CA: The Rand Corporation.

Sonenstein, Freya; Pleck, Joseph; and Ku, Leighton. "At Risk of AIDS: Behaviors, Knowledge and Attitudes among a National Sample of Adolescent Males." Paper presented at Population Association of America Annual Meeting, March, 1989.

U.S. Department of Education, Office of Educational Research and Improvement. Youth Indicators 1988. Washington, D.C.: U.S. Government Printing Office.

Weder, W. "Teenage Parenting and AFDC Recipiency," briefing for FSA Staff, sponsored by Office of Policy, Division of Research, Demonstrations and Evaluations, U.S. Department of Health and Human Services. No date.

Wertheimer, R. and Moore, K. "Teenage Childbearing and Public Costs." Final Report to National Institute for Child Health and Human Development. Washington, D.C.: The Urban Institute, 1982.

William T. Grant Foundation Commission on Work, Family and Citizenship. The Forgotten Half: Non-College Youth in America. Interim Report, 1988.

CHILD WELFARE SERVICES

When parents are having difficulties which jeopardize the health and well-being of their children, the child welfare system is supposed to provide substitutes for family functions if necessary, provide services to improve family functioning, and insure that the children are protected. This summary divides problems of child welfare services into three areas. The first area is Child Abuse and Neglect, since most children enter the child welfare system as a result of allegations of child maltreatment. Because many children require temporary placement outside the home for their protection and well-being, the Adequacy of Foster Care Services is the second problem area. For those children in need of permanent placement outside their birth families, the Adequacy of Adoption Services is the third problem area.

Child Abuse and Neglect

1. Definition of Problem Area

No standarized definition of child abuse exists. However, child maltreatment may be categorized into four classifications: physical abuse, neglect, sexual abuse and emotional maltreatment.

- Physical abuse--nonaccidental injury which may include severe beatings, burns, strangulation or human bites.

- Neglect--the failure to provide a child with the basic necessities of life: food, clothing, shelter, medical care or education.

- Sexual abuse--the exploitation of a child for the sexual gratification of an adult, as in rape, incest, fondling of the genitals, exhibitionism, or pornography.

- Emotional maltreatment--a pattern of behavior that attacks a child's emotional development and sense of self worth. Examples include constant criticizing, belittling, insulting, rejecting, and providing no love, support or guidance.

Child abuse is not typically just one attack or one instance of a failure to meet a child's needs. Usually child abuse involves a pattern of behavior which continues over a period of time. The longer the duration, the more difficult it is to stop and the more serious become the consequences to the child.

2. Trends

The exact scope of child maltreatment in this country is subject to wide debate. Interviews with random samples of households or individuals consistently project higher

incidence and prevalence rates than indicated by formal reporting data. Household surveys on the level of intimate violence in America confirm that a minimum of 1.0 million children ages 3-17 residing in two parent families are subject to serious physical abuse each year (Straus, Gelles and Steinmetz, 1980; Straus and Gelles, 1986). However, these numbers focus on only a portion of all maltreatment. They provide few, if any, insights into the number of children who experience chronic emotional maltreatment or fall victim to sexual abuse. A 1978 survey of 930 randomly selected women in San Francisco revealed that 28% of the respondents had experienced unwanted sexual touching and other forms of abuse before the age of 14 and that the percentage of victims increased to 38% if one included all episodes occurring before the women turned 18 (Russell, 1984). Finkelhor (1984) reported that 6% of all males and 15% of all females in his random sample of 521 Boston parents had experienced sexual abuse before age 16 by a person at least five years older.

These and similar studies have been used by child advocates to define the broad parameters of the maltreatment problem. Federal and local public officials, however, must rely upon more formal estimates of the problem. The American Association for Protecting Children (AAPC, 1988) notes that over two million children were reported as suspected victims of maltreatment in 1986, a 200% increase over the number reported in 1976, the first year national data on child abuse reporting were collected. While the increase in the reporting rates has tapered off in the past two years, increasing at an annual rate of only 3% in both 1987 and 1988, the number of maltreatment victims continues to outpace available resources.

While the rate of increase in reporting levels is on the decline, caseloads in a majority of States reflect increases in the percentage of multi-problem families. Caseworkers are often faced with the complex issues of homelessness, substance abuse and physical or mental disabilities within a single case. Abuse of drugs such as crack and cocaine are increasingly more prevalent, intensifying the severity of cases and resulting in an increased need for out-of-home placements. At least 1 in 10 babies born in the United States, or 375,000 infants annually, has been exposed to illegal drugs taken by their mothers during pregnancy (Chasnoff, 1989).

Following a trend noted in 1980's, child abuse and neglect related fatalities are continuing to increase. Although relatively small in absolute numbers, reported child maltreatment related fatalities rose 5% in 1988, totaling over 1,200. Since 1985 the number of reported child abuse fatalities has increased over 36%. Whether these figures simply represent a more accurate count of a consistent problem or an actual increase in the number of fatalities, they are still disturbing. Over the past three years, a minimum of three children a day have been reported as fatal victims of child abuse.

Support for the persistence, if not growth of the child abuse problem, also is found in the most recently completed federally funded National Incidence Study (Westat, 1988). This study confirmed that over one million children, 16 out of every 1,000, were identified by child service professionals as abused or neglected in 1985. This figure represents a 66% increase over the number identified during a similar study

conducted in 1980. The largest increases were noted in cases involving moderate physical abuse and all forms of child sexual abuse. While not significant, increases also were noted in the rates of fatal and serious physical abuse; all forms of emotional abuse; abandonment and the refusal to provide a child necessary health care or education. Most forms of emotional neglect also increased.

Further, despite extensive efforts to train professionals in their reporting responsibilities, the 1985 study determined little change had occurred in the percentage of cases known to professionals which were formally reported. Less than one-third of the child abuse cases identified by law enforcement officials, medical personnel, educators, and social service providers are reported to child protective service agencies and substantiated (Westat, 1988). This percentage ranges from a low of 16% for day care providers and 24% for teachers to a high of 66% for hospital personnel and 61% for local police.

Given the reporting problems, there is great debate over the actual level of child maltreatment. Critics argue that relying solely upon official reports of maltreatment or the National Incidence Study for accurate assessments of the level of child maltreatment is faulty because the actual incidence levels most likely exceed either of these projections.

3. Number of Children in Need/Service Population

Among the 1.9 million children reported by AAPC as maltreated in 1985, about 42% or 795,000 children were substantiated as abused or neglected (Select Committee on Children, Youth and Families, 1987). However, reliable data are not available from States on the number of abused and neglected children actually receiving services.

4. Expenditures

Where available, State and Federal expenditure data generally do not distinguish between expenditures for child abuse, foster care and adoption. Instead these problem or service areas are reported together under the heading of Child Welfare services. Thus, this discussion covers overall Child Welfare expenditures, not just expenditures for services related to child abuse.

Title XX, the Social Services Block Grant (SSBG), is the largest source of Federal funds available to States for child protective services. Overall, Title XX appropriations in 1985 were $2.7 billion. GAO has estimated that approximately $500 million of this goes to Child Welfare.

Title IV-B of the Social Security Act provides States with matching funds for the provision of Child Welfare services. Each State is reimbursed for 75% of its expenses up to its alloted proportionate share of appropriations. In FY 1987, $222.5 million was spent on services supporting child protection, foster care an adoption under Title IV-B.

The Child Abuse Prevention and Treatment Act (CAPTA) is the only Federal program solely designed to prevent, identify and treat child abuse and neglect. It created the National Center on Child Abuse and Neglect (NCCAN) which has been appropriated approximately $25 million a year by Congress. The majority of the funds available through CAPTA are distributed to States through formula grants for use with any child abuse and neglect related activities.

With the creation on the first State Children's Trust Fund in 1980, a special pool of money was made available solely for the development and dissemination of child abuse prevention services. Children's Trust or Prevention Funds are now in place in 45 States and genereated revenues in excess of $27 million in 1988 (Select Committee on Children, Youth and Families, 1987).

5. Cost Per Case

The types of intensive treatment services offered by federal demonstration programs suggest that thoughtful interventions with those families reported for maltreatment can run between $2,860 per family per year for lay therapy and supportive services to over $28,000 per family per year for comprehensive therapeutic services, including remedial services for children.

6. Cost to Address Unmet Service Need

The costs associated with remediating the consequences of maltreatment are staggering, as reported in a detailed benefit-cost analysis developed by Daro for child maltreatment in 1983 (1988). According to AAPC data for 1983, serious physicial abuse cases, a category which represented only 3% of all reports, cost society annually at least $20 million in hospitalizations, and $7 million in rehabilitation costs to address the victim's immediate physical injuries and developmental problems. The Office of Technology Assessment has concluded that Daro's estimates of the foster care costs of maltreated children in 1983 were too high. However, their adjusted numbers are still staggering. OTA estimated that the foster care costs of children maltreated in 1983 were $475 million in the first year and $6.7 billion long-term.

If only the severely abused children reported in 1983 (3% of all reports) received intensive therapeutic services for one year, the costs would have exceeded $662 million. Offering quality therapeutic care to all families experiencing child maltreatment problems would likely run into the billions of dollars. Even prevention efforts--which of necessity would be directed at whole segments of the population--have significant, although substantially lower, costs associated with them.

7. Effectiveness of Intervention

Evaluations of child abuse treatment programs over the past ten years have consistently underscored their limitations. Among protective service caseloads, reincidence rates of 30 to 40% are common. Federal and State funded evaluations of

sophisticated clinical demonstration projects, consisting of weekly contact for 12 to 18 months, report reincidence among one-third to one-half of all clients. Further, at termination, more than half of the clients served by these programs are considered by their service providers to remain at risk of abusing their children in the future.

Prevention services have been found much more effective. The richest body of empirical evidence regarding the effectiveness of prevention services is found among educational and support services targeted to new parents. Both home-based programs and center-based programs have demonstrated a wide range of positive client outcomes. Specific gains have included improved mother-infant bonding and maternal capacity to respond to the child's emotional needs; developmental needs; fewer subsequent pregnancies; more consistent use of health care services and job training opportunities; and lower welfare use, higher school completion rates and higher employment rates. In identifying the types of parents most likely to benefit from these educational and supportive services, several have noted particular success with young, relatively poor mothers and with mothers who felt confident in their lives prior to enrolling in the program.

Citations for this section include: Cohn and Daro, 1988; Daro, 1988; Herrenkohl, Herrenkohl, Egolf and Seech, 1979; Laughlin and Weiss, 1981; Afholter, Connell & Nauta, 1983; Dickie and Gerber, 1980; Field, Widmayer, Stringer & Ignatoff, 1980; O'Connor, Vietze, Sherrod, Sandler & Altmeier, 1980; Gabinet, 1979; Gray, 1983; Gutelius, Kirsch, MacDonald, Brooks & McErlean, 1977; Larson, 1980; Love, Nauta, Coelen, Hewett & Ruopp, 1976; Olds, Chamberlin & Tatlebaum, 1986; Travers, Nauta and Irwin, 1982; Badger, 1981; McAnarney, Roghmann, Adama, Tatlebaum, Kash, Coutler, Plume & Charney, 1978; Powell, 1986; and Polit, 1987.

8. Public Opinion

The public believes such behavior as physical punishment and yelling and swearing at children is harmful. One-third of the public participating in a Survey of randomly selected adults across the country believe that physical punishment "very often or often" results in injury to a child and nearly three-quarters share this opinion regarding repeated yelling and swearing at a child (Schulman, Ronca and Bucavales, 1989).

According to a 1988 public opinion poll, six in ten Americans are against corporal punishment in the schools in principle and without exception. A majority of Americans (61%) say they cannot even imagine a hypothetical situation when they would approve of a public school teacher hitting a student. This percentage is a marked increase over the 51% who conveyed this view in a survey including the exact same question in 1968.

Public support is also strongly in favor of key prevention efforts currently in place in many States. Over 90% agree that all elementary schools should offer instruction which teachers children to protect themselves from child abuse, especially sexual abuse. In addition, over 80% of the public agree that educational and support services,

including health professionals who visit parents in their homes, should be available for all parents from the time their first child is born.

Adequacy of Foster Care Services

1. Definition of Program Area

Foster Care is placement of a child on a 24-hour basis outside the home under the jurisdiction of a primary State child welfare agency or a child placing agency under contract with the State. There is considerable variation among States as to what services comprise foster care. It can include family foster homes, group residential treatment centers, emergency shelters, certain secure and independent living arrangements, and placement with family or relative, if under the supervision of the primary child welfare agency.

2. Trends

Unfortunately, there is no national reporting system which captures the number of children receiving foster care services. Data which are available are estimates collected on a voluntary basis from States (and not all States participate). These voluntary data suggest that while the foster care population has been relatively stable since 1961, there is evidence that increases have occurred in recent years. The voluntary data report 262,000 children at a point in time in 1982, increasing to 276,000 children at a point in time in 1985 (Voluntary Cooperative Information System (VCIS), 1988 cited in Committee on Ways and Means, 1989). However, ACYF has estimated that 375,000 children were in foster care in June, 1986 (ACYF, 1988 cited in Select Committee on Children, Youth and Families, 1989). The median length of time spent in care has become shorter, decreasing from 27 months in 1977 to 18 months in 1985, although since 1982 the median length of stay has remained at 18 months (Committee on Ways and Means, 1989).

The children entering foster care tend to be older, more troubled, and have more serious and complex problems than they had in past years. An estimated 18% of all reported cases of abuse and neglect result in a foster care placement decision (AAPC, cited by Office of Technology Assessment, 1988). In addition, an estimated 70% of the children entering substitute care have family problems related to substance abuse. Finally, there are growing special problems associated with drug addicted and AIDS infected infants entering the foster care system (Select Committee on Children, Youth, and Families, 1989).

Nationally, the trend has been to increase permanency planning and to reunify the child with his or her biological parent(s) whenever possible. Supported by the passage of State and Federal laws such as the Child Welfare and Adoption Amendments of 1980 (P.L. 96-272), the goal of reunification with parent or placing with relative has increased from 39.2% in 1982 to 51.7% in 1985. Over that same period the

goal of adoption for foster care children has decreased from 16.5% to 13.1% (VCIS, 1988 cited by Committee on Ways and Means, 1989). Further, the number of children placed in institutions has declined from 70,280 in 1977 to 27,500 in 1982 (Select Committee on Children, Youth and Families, 1989).

The rise in the number of foster care placements is even more pronounced in areas where there is a larger incidence of homelessness, drugs, and abuse and neglect--all factors placing children at greater risk of out-of-home placement. For example, in New York City, 20,302 children were in foster care in February 1988, almost 500 more than were in care the month before and 20% more than in 1983 (NYC Human Resources Administration, 1988, cited by Select Committee on Children, Youth, and Families, 1989). Also, in Los Angeles County the number of dependency judicial reviews increased 229% between 1981 and 1987 (Little Hoover Commission, 1987 cited by Select Committee on Children, Youth, and Families, 1989).

3. Number of Children in Need/Service Population

At the end of 1985, the VCIS system reported an estimated 276,000 children in foster care, with 270,000 children reported to be in care at the beginning of the year and 460,000 children reported as being served during the year. (Select Committee on Children, Youth and Families, 1989).

Of all children in foster care in 1985, 40% were in care for under one year, 61% were in care for under two years, and 38% were in care for greater than two years. Of this group, 12% has been in care two to three years, 11% had been in care three to five years, and 14% had been in care for five years or more (VCIS, 1988 cited by Select Committee on Children, Youth and Families, 1989).

The most common placement is family foster care (includes group homes in most States), which comprised about 60% of all placements reported in 1985. The next most common placement is group residential care, which comprised 18% of all placements. The remaining placements were in emergency shelters, 1.3%; independent living programs, 1%; secure facilities, 7%; and living with parents or relatives, 11%. Children with handicaps represented almost 16% of the total in care (Hill, Lakin et al., 1987).

Of those entering foster care, the vast majority were new entrants (75%), while 25% were reentrants. Of the reentrants, 20% had experienced two to four placements and 6% had been in five or more placements. A majority of new entrants entered due to abuse and neglect. Parental conditions or absence accounted for another 16% and child-related reasons accounted for almost 12%. Of the children in care, 45% were thirteen years old or older, 29% were ages six through twelve, and 22% were ages one through five (VCIS, 1988 cited in Committee on Ways and Means, 1989).

4. Expenditures

(See discussion under Child Abuse of overall child welfare expenditures)

5. Cost Per Child

Data are not available on how much States or the Federal government spend on foster care, making it difficult to calculate a cost per child. A study was conducted which determined that the average cost per child paid to foster families in 1982 was $178 per-month or $2,136 annually (calculated from Select Committee for Children, Youth, and Families, 1989). However, it is important to note that there are different costs associated with the different types of foster care. Family foster care is the least expensive type of care. Group residential care is substantially more expensive because its costs include the cost of space, 24-hour staffing, and education.

6. Cost to Address Unmet Service Need

Data are not available to determine what it would cost to fill the unmet need for foster care services. However, it is known that existing funds are not adequate to address service needs. In almost every State, more Foster Care parents are needed, as well as additional child welfare staff. Burnout for child welfare workers is also a problem. Turnover among protective services staff in New York City was 67% in 1986, according to the Children's Defense Fund (National Health Policy Forum, 1989).

Adequacy of Adoption Services

1. Definition of Problem Area

Adoption is defined as the judicial act of creating the legal relationship between parent and child where it previously did not exist (Committee on Ways and Means, 1987). State laws governing adoption require certain legal processes and the provision of child welfare services intended to protect the child and others who are involved in the adoption. The process of adoption may be coordinated by private or public agencies. Since there are no nationwide data available on private adoptions, this discussion will focus on public adoptions. In particular, this discussion will examine the unmet need for adoption among children who are already in foster care placements.

2. Trends

The profile of the child in need of adoption has changed over the past two decades. The availability of healthy infants has decreased dramatically due to the legalization of abortion and the increasing number of unmarried teenagers choosing to keep their children. However, there has been an increase in the number of older children awaiting adoption, due to social problems such as child abuse, drug dependency and Aids. Further, these children are often quite troubled. Efforts to put these older children in permanent placements have served to increase the level of special needs in the population of children awaiting adoption. This is evidenced by the fact that in 1982 an estimated 28% of all public adoptions were special needs

adoptions. In 1985, this percentage increased to 62% (Committee on Ways and Means, 1987). In addition, people are adopting special needs children at a higher rate (62%) than the percentage of those children available for adoption (51%) (Committee on Ways and Means, 1989).

To provide incentive and support to those individuals adopting special needs children State and federal laws have been enacted to help remove financial and other barriers to adoption. The Adoption Assistance and Child Welfare Amendments of 1980 (P.L. 96-272) authorized a new entitlement program of matching funds for State programs which determine that a child has special needs and would not be able to be adopted without some form of assistance provided to him or his adoptive parents on his behalf. This program entitles AFDC and SSI eligible children to a monthly adoption assistance payment, Medicaid eligibility, and partial payment to the State for administrative and training expenses related to the adoption process (Committee on Ways and Means, 1989). In 1987, the law was further amended to allow all children with special needs to receive some form of adoption assistance whether they are AFDC eligible or not (1986 Tax Reform Legislation P.L. 99-514, cited by Committee on Ways and Means, 1987).

3. Number of Children in Need/Service Population

There are no official estimates of the number of children awaiting adoption and being adopted in this country each year. The only national data available are collected by the American Public Welfare Association through the Voluntary Cooperative Information System (VCIS) and are based on voluntary reporting from States on adoptions which result from substitute care. Recognizing there was a problem with insufficient data on adoption, the 1986 Budget Reconciliation Act mandated the establishment of an advisory group to identify the type of information necessary for developing national adoption and foster care policies. Final regulations for this new data base were due in December 1988 and the system is to be implemented by 1991 (Committee on Ways and Means, 1989).

One methodology for determining the level of unmet need for adoption is to compare the number of children targeted for adoption at the beginning of the year with the number of children whose adoptions were finalized, and the number available for adoption at the end of the year. At the start of fiscal 1985, an estimated 38,000 to 40,000 children nation-wide had a permanency planning goal of adoption. By the end of the year approximately 50% or 17,000 to 20,000 children were adopted and 37,000 to 39,000 were legally free for adoption (VCIS, 1987 cited by Committee on Ways and Means, 1989). Thus approximately 20,000 children were still awaiting adoption at the end of the year, assuming the rate of adoption and the number of children eligible for adoption remained constant.

The characteristics of children awaiting adoption differ from those whose adoptions have been finalized:

- On the basis of race, black children have the greatest unmet need for adoption. In 1985, a greater percentage of white, hispanic, and other racial groups were adopted than the percentage available for adoption. (white children--58% adopted to 52% available; hispanic children--9% adopted to 7% available; and other groups--10% adopted to 3% available). Conversely, the percentage of black children adopted (23%) was lower than the percentage of children available for adoption (38%) (VCIS, 1987 cited by Committee on Ways and Means, 1989).

- On the basis of age, adoption rates for children decrease dramatically with increasing age and the demand is clearly for younger children. For a child 0 to 5 years of age there was a 50% adoption rate. By the time a child was between 13 and 18 years of age the adoption rate decreased to 11%. In addition, nearly 20% more children between the ages of 0 and 5 years were adopted (50%) than those awaiting for adoption (31%). Of children ages 6 through 12, more were awaiting adoption (44%) than adopted (30%). In the 13 to 18 age bracket more than twice as many children were awaiting adoption (25%) than adopted (11%) (VCIS, 1987 cited by Committee on Ways and Means, 1989).

The median length of time children waited to be adopted was 14 months. However, it was found that 25% of the children had been awaiting adoption for more than 3.1 years (VCIS, 1985). There was no information correlating length of time waiting to be adopted with racial group or age.

4. Expenditures

(See discussion under Child Abuse of overall child welfare expenditures)

5. Cost Per Child

Data are not available to estimate the cost per child for public adoption. However, the Federal government estimates it will be spending an average of $2908 per child annually on the adoption subsidy program for special needs children in 1989 (calculated from Department of Health and Human Services, 1987, cited by Committee on Ways and Means, 1989). This cost only reflects the reimbursement to States for monthly maintenance payments to AFDC/SSI eligible children, State administrative and training costs associated with these adoptions, and the one-time reimbursement for costs of non-AFDC/SSI special needs children. It does not reflect the associated costs of non-special needs and special needs adoptions which may be paid for out of Title IVB, Title XX, and Title XIX Medicaid funds or those costs which are totally State funded.

6. Cost to Address Unmet Service Need

Again, data are not available to estimate what the costs would be to close the gap for the estimated 20,000 children waiting to be adopted. If 62% of those children were special needs children, it is estimated that the adoption subsidy program would increase by approximately $36 million, assuming that all 20,000 were adopted in one

year. This, however, does not take into account the other special and non-special needs adoption costs which may be paid for out of Title IV-B, Title XIX, and Title XX funds or the costs that States fund themselves. Also to be considered are the offsetting savings in foster care expenditures because many of these children are already served under foster care programs.

References

Affholter, D., Connell, D. & Nauta, M. "Evaluation of the Child and Family Resource Program: Early Evidence of Parent-Child Interaction Effects." Evaluation Review, 7 (1), 65-79, 1983.

American Association for Protecting Children. Highlights of Official Child Neglect and Abuse Reporting. Denver: American Humane Association, 1988.

Badger, E. Effects of a Parent Education Program on Teenage Mothers and Their offspring, in K.G. Scott, T. Field, & E. Robertson (eds.), Teenage Parents and Their Offspring, New York: Grune & Stratton, 1981.

Bolton, F. & Bolton, S. Working With Violent Families: A Guide for Clinical and Legal Practitioners. Newbury Park, CA: Sage Publications, 1987.

Chasnoff, I. Personal Communication, Chicago, IL: The Perinatal Center for Chemical Dependence, 1989.

Cohn, A. & Daro, D. "Is Treatment Too Late: What Ten Years of Evaluative Research Tell Us." Child Abuse and Neglect, 11(3), 433-442, 1988.

Committee on Ways and Means. Background Material and Data on the Programs within the Jurisdiction of the Committee on Ways and Means. Washington, D.C.: U.S. Government Printing Office, 1987 and 1989 volumes.

Daro, D. Confronting Child Abuse. New York: Free Press, 1988.

Daro, D. & Mitchel, L. Child Abuse Fatalities Remain High: The Results of the 1987 Annual Fifty State Survey. Chicago, IL: National Committee for Prevention of Child Abuse, 1988.

Daro, D. & Mitchel, L. Child Abuse Fatalities Continue to Rises The Results of the 1988 Annual Fifty State Survey. Chicago, IL: National Committee for Prevention of Child Abuse, 1989.

Dickie, J. & Gerber, S. "Training in Social Competence: The Effects on Mothers, Fathers and Infants." Child Development, 51, 1248-1251, 1980.

Field, T., Widmayer, S., Stringer, S., & Ignatoff, E. "Teenage, Lower-Class Black Mothers and Their Pre-Term Infants: An Intervention and Developmental Follow-up." Child Development, 5, 426-436, 1980.

Finkelhor, D. Child Sexual Abuse: New Theory and Research. New York: Free Press, 1984.

Gabinet, L. "Prevention of Child Abuse and Neglect in an Inner-City Population: II. The Program and The Results." Child Abuse and Neglect, 3 (3/4), 809-817, 1979.

Gray, E. "Final Report: Collaborative Research of Community and Minority Group Action to Prevent Child Abuse and Neglect," Vol. 1: Perinatal Interventions. Chicago: National Committee for Prevention of Child Abuse, 1983.

Gutelius, M., Kirsch, A., MacDonald, S., Brooks, M. & McErlean, T. "Controlled Study of Child Health Supervision: Behavior Results." Pediatrics, 60, 294-304, 1977.

Herrenkohl, R., Herrenkohl, E., Egolf, B. & Seech, M. "The Repetition of Child Abuse: How Often Does It Occur?" Child Abuse and Neglect, 3 (1), 67-72, 1979.

Hill, B.K., Lakin, K.C., Novak, A.R. and White, C.C. Foster Care for Children and Adults with Handicaps: Child Welfare and Adult Social Services. Minneapolis: University of Minnesota, Report #23, October, 1987. [http://aspe.hhs.gov/daltcp/reports/fosteres.htm]

Kaufman, J. & Zigler, E. "Do Abused Children Become Abusive Parents?" American Journal of Orthopsychiatry, 57(2), 186-192, 1987.

Larson, C. "Efficacy of Prenatal and Postpartum Home Visits on Child Health and Development." Pediatrics, 66, 191-197, 1980.

Laughlin, J. & Weiss, M. "An Outpatient Milieu Therapy Approach to Treatment of Child Muse and Neglect Problems." Social Casework, 62 (2), 106-109, 1981.

Love, J., Nauta, M., Coelen, C., Hewett, K. & Ruopp, R. National Home Start Evaluation: Final Report. Findings and Implications. Ypsilanti, MI: High Scope Educational Research Foundation, 1976.

McAnarney, E., Roghmann, K., Adams, B., Tatlebaum, R., Kash, C., Coulter,.M., Plume, M. & Charney, E. "Obstetric, Neonatal and Psychosocial Outcome of Pregrfdnant Adolescents." Pediatrics, 61 (2), 199-205, 1978.

O'Connor, S., Vietze, P., Sherrod, K., Sandler, H. and Altemeir, W. "Reduced Incidence of Parenting Inadequacy Following Rooming-in." Pediatrics, 66, 176-182, 1980.

Office of Technology Assessment. Healthy Children: Investing in the Future, OTA-H-345. Washington, D.C.: U.S. Government Printing Office, February, 1988.

Olds, D., Chamberlin, R. & Tatlebaum, R. "Preventing Child Abuse and Neglect: A Randomized Trial of Nurse Home Visitation." Pediatrics, 78, 65-78, 1986.

Polit, D. "Routes to Self-Sufficiency: Teenage Mothers and Employment." Children Today, 6-11, 1987.

Powell, D. "Parent Education and Support Programs." Young Children, March, 47-53, 1986.

Russell, D. Sexual Exploitation: Rape, Child Sexual Abuse, and Sexual Harassment. Beverly Hills, CA: Sage Publications, 1984.

Schulman, Ronca and Bucuvales, Inc. Public Attitudes and Actions Regarding Child Abuse and Its Prevention: 1981. Chicago, IL: National Committee for Prevention of Child Abuse, 1989.

Seitz, V., Rosenbaum, L. & Apfel, N. "Effects of Family Support Intervention: A Ten-Year Follow-up." Child Development, 56, 376-391, 1985.

Select Committee on Children, Youth, and Families, U.S. House of Representatives. Abused Children in America: Victims of Official Neglect. Washington, D.C.: U.S. Government Printing Office, 1987.

Select Committee on Children, Youth, and Families. "Abused Children in America: Victims of Official Neglect." Washington, D.C.: U.S. Government Printing Office, 1988.

Select Committee on Children, Youth, and Families. "Report on the Activities for the Year 1988." Washington, D.C.: U.S. Government Printing Office, 1988.

Straus, M., and Gelles, R. "Societal Change and Change in Family Violence from 1975-1985 as Revealed by Two National Surveys." Journal of Marriage and the Family 48 (August 1986) 465-479.

Straus, M., Gelles, R., & Steinmetz, S. Behind Closed Doors: Violence in the American Family. Garden City, NY: Anchor Press/Doubleday, 1980.

The Voluntary Cooperative Information System. Characteristics of Children in Substitute and Adoptive Care. Washington, D.C.: The American Public Welfare Association, 1983.

The Voluntary Cooperative Information System. "Additional Summaries of the 1982 VCIS Adoption Data." Washington, D.C.: American Public Welfare Association, 1985.

Travers, J., Nauta, M. and Irwin, N. The Effects of a Social Program: Final Report of the Child and Family Resource Program's Infant and Toddler Component. Cambridge, MA: Abt Associates.

Westat Associates. Study of the National Incidence and Prevalence of Child Abuse and Neglect. Washington, D.C.: U.S. Government Printing Office, 1988.

LACK OF CHILD CARE

1. Definition of Problem Area

Child care is non-parental care of children while parents are employed, in school or job training, or looking for work. It can include care by relatives, friends and neighbors (paid and unpaid) as well as care in child care centers, preschool programs, licensed family day care, and before and after school programs. Children from infancy through age 13 are customarily defined as needing child care.[1]

While families at all income levels need child care when parents work, this summary focuses on the child care needs of low income families. Lack of affordable child care is a greater barrier to employment for mothers in low income families, especially mother-headed families, than among higher income mothers (O'Connell and Bloom, 1987). Consistent with our targeted focus, the need for child care which remains unmet will be measured by the proportion of low income mothers who would seek employment if child care were available.

2. Trends

The labor force participation rates of mothers with children under age 14 has increased steadily since 1946. In 1985, 49 percent of children under age 6 and 60 percent of children 6-13 had mothers in the work force. In the last decade the most remarkable change has been the astonishing 57 percent rise in the proportion of children under age 1 with employed mothers. More than one-half of mothers with infants are now in the labor force. If current trends continue by 1995 over two-thirds of preschool children and three-quarters of schoolage children will have their mothers in the work force (Hofferth and Phillips, 1987).

The employment rates of low income women have not kept pace with the participation rates of other women. The rate of labor force participation among mothers of poor children is one-fifth (7%) that of non-poor children (36%), based on the 1988 Current Population Survey. Lack of child care is believed to be one of the reasons for this difference. In 1982 it was estimated that the labor force participation rates for women in families with incomes less than $15,000 annually would increase from 45 percent to 65 percent if affordable child care were available (U.S. Census Bureau, 1982 cited by O'Connell and Bloom, 1987). This was, however, based on weak data.

Another trend worth noting is that the type of care used by parents when they are employed has changed over the last two decades. The most striking change is that the use of group care programs (centers, preschool programs and other group-based programs) tripled for children under the age of 3 as well as for preschoolers ages 3 and

[1] In this analysis of child care we have not included a discussion of parental leave and family assistance options which would support parents' efforts to care for their own children.

4. While 6 percent of children under 2 were in full time group care in 1965, the proportion was 16 percent in 1982. For 3 and 4 year olds the proportions in full time group care rose from 13 percent to 40 percent. The use of family day care homes has also shown a steady rise from 24 percent to 36 percent for children under 3; the use of relatives and in-home babysitters has declined over the same time period. However, relatives remain the major providers of child care for preschool age children, providing just over 40 percent of the full time care of children ages 3 and 4 (Hofferth and Phillips, 1987).

A final trend to note Is the rate of federal spending for child care. Between 1977 and 1986 federal spending for child care increased from $3.8 billion to $5.5 billion.[2] However, there has been a decided shift in the distribution of child care benefits. Virtually all the increased benefits since 1977 have gone to middle and upper income families through the child and dependent care tax credit. Independent of the tax credit, federal spending for child care declined 25 percent between 1977 to 1986, from $2.8 billion to $2.1 billion (1986 dollars) (Robbins, 1988).

3. Number of Children and Families in Need

Criteria for determining the extent of the need for child care services can vary. The Department of Labor (DOL) recently estimated that there are 16.3 million families with children under age 14 and working parents (12.8 million married couples with two working parents and 3.5 million mother headed families with one working parent) all of whom need child care.[3] In addition, DOL estimated there are 3.7 million welfare mothers with 3.1 million children under the age of 6 and 2.9 million children between the ages of 6 and 13 who might , use child care to seek employment. DOL also targeted an estimated 600,000 teen mothers (200,000 of whom are also on AFDC) who might use child care to further their education and training (U.S. Department of Labor, 1988).

Rather than focus on the current users of child care to define the need for the services, we have chosen to target what we believe is a measure of the unmet need: families who do not currently use child care but who would if it were affordable and available. In particular we target low income families for whom child care problems may pose substantial barriers to work force participation and economic self sufficiency.[4]

In 1982 1.7 million mothers of preschoolers in low income families (less than $15,000 income) were in the labor force, but it is estimated that 2.3 million low income mothers would have been in the labor force if affordable child care were available. These data suggest that 600,000 low income mothers of preschool age children would have entered the work force in 1982 if subsidized child care were available. This prediction is based on non-employed mothers' responses to a question about whether they would look for work if child care were available to them at a reasonable cost (O'Connell and Bloom, 1987). More recent data do not appear to be available, although

[2] Both amounts are stated in 1986 dollars.
[3] Based on March 1987 Current Population Survey data.
[4] This definition of unmet need does not address the issue of children of working parents who are in inadequate care.

the Survey of Income and Program Participation might provide information to update this estimate.

Another group with unmet child care needs are families in which children are placed in self care. This appears to be a rare although potentially disastrous occurrence among preschool children and so reliable estimates of incidence are not available. Among school age children (6-13) self care is more common. In 1984, 2.1 million school age children (out of a possible 28.8 million) regularly spent time during the nonschool hours with no adult supervision. There were 400,000 5-8 year-olds in self care, 800,000 9-11 year olds, and 863,000 12-13 year-olds. Children in self care from low income families (less than $20,000 annually) numbered 895,000 (U.S. Bureau of the Census, 1987).

Because recent information about the child care arrangements of low income mothers is not available, information about the child care arrangements of mothers with low levels of educational attainment is provided as a proximate measure of income. In 1984-85 employed mothers who were not high school graduates used the following types of primary child care for their children under age 5:

Care by Father	19.8%	Care by Mother while Working	8.9%
Care by Other Relatives	34.7%	Babysitter in Home	6.4%
Care in Someone Else's Home	14.8%	Day Care Center	7.8%
Preschool Programs	7.7%		
(Source: U.S. Bureau of the Census, 1987, Table 4)			

For children ages 5-13 they used the following primary arrangements:

Care by Father	9.2%	Care by Mother while Working	1.4%
Care by Other Relatives	9.1%	Babysitter in Home	0.7%
Care in Someone Else's Home	0.6%	Day Care Center	1.7%
School	74.5%	Child Care for Self	3.0%
(Source: U.S. Bureau of the Census, 1987, Table 4.)			

4. Child Care Expenditures

The primary funding source for child care in the U.S. is the fees that parents pay to purchase child care. In 1985 parents spent $12.7 billion on care (Data Resources, 1989). Federal spending on child care was estimated at $5.5 billion in 1986 and at $6.9 billion in Fiscal Year 1988. Federal expenditures in FY 1988 included the following:

Tax Credits & Deductions	$4.0 billion	primarily helps middle class
Head Start	$1.3 billion	part-day programs, low income children
Food Programs	$0.8 billion	child care programs with low income children
Social Service Block Grant	$0.6 billion	child care programs at State discretion
Job Training/Education/Welfare Programs	$0.14 billion	child care for program participants
Child Care in Military Installations	$0.01 billion	
Other Expenditures	$0.01 billion	Bureau of Census, Grants for State planning & training, Child Welfare Demos
TOTAL	**$6.9 billion**	
(SOURCE: Department of Labor, 1988)		

State and local governments also subsidize child care through tax benefits and program subsidies but data are not available on the extent of this aid (Department of Labor, 1988).

5. Cost Per Family

In 1985 families with pre-school age children paid an average of $1,652 per year ($138 per month of $32 per week) for child care. This amount equalled 6-7 percent of their total family spending. However, among low income single parent families, expenditures for child care averaged 14 percent of total family spending (Data Resources, 1989). Spending for both full time and part time child care are included in these statistics.

The costs of full time child care are substantially higher. In 4 major cities in 1985 full time care in centers for children under age 2 cost between $50-$150 per week; in a family day care home the cost was between $45-$160; and in an in-home babysitting arrangement the cost was $165-$340.

6. Cost to Address Unmet Service Need

We have estimated that 600,000 low income families have an unmet need for child care. At an average annual cost of $1,652 per family, the cost of closing this gap would be about $1 billion. Of course the net cost would be less because of anticipated savings in the AFDC program and additions to income tax revenues.

7. Effectiveness of Intervention

By its definition, providing child care services will fill the need for child care. This paper does not seek to examine alternative methods for financing child care, e.g., direct subsidies, tax credits, modified regulations, etc. While the relation of child care to the work status of welfare and poor mothers (or fathers) is clear, the extent to which

increasing availability of child care increases work effort and decreases poverty or welfare dependency is less clear.

8. Public Opinion

Numerous polls indicate the strong public concern about the lack of availability of child care services and support for increased government spending for day care. A Washington Post-ABC News survey found that 61 percent favored increased federal spending on "day care programs which take care of the children of working parents who can't afford it." (Morin, 1989) A June 1988 Gallup Poll found 45 percent of those surveyed felt the government should do more about the availability and affordability of child care services (Gallup Poll, 1988). A 1988 poll about child care services indicated that about three-quarters of voters lean in favor of government support of child care, as opposed to believing that government support might discourage parents from staying home with their children (Martilla and Kiley, 1988). Thus, while some Americans may still be concerned that child care may interfere with normal family roles, the great majority believe a government role is appropriate.

References

Data Resources/McGraw Hill. Differences in Overall Spending Patterns and Spending on Child Care by Family Type: An Exploratory Study Using the Consumer Expenditure Survey, January, 1989. [http://aspe.hhs.gov/daltcp/reports/spediffes.htm]

Gallup Poll. AARP Survey of Family Issues: Analytical Report. Princeton: Gallup Organization, June 1988

Hofferth, Sandra L. and Deborah A. Phillips. "Child Care in the U.S. 1970-1995." Journal of Marriage and the Family, 49 (Aug. 1987) 559-571.

Martilla and Kiley, Inc. A Survey of American Voter Attitudes Concerning Child Care Services: Highlights and Key Findings. Boston: Martilla and Kiley, June 1988.

Morin, R. "Drug Abuse Leads the Nation's Worries," Washington Post. August 23, 1989.

O'Connell, Martin and David E. Bloom. "Juggling Jobs and Babies: America's Child Care Challenge." Washington, D.C.: Population Reference Bureau, Inc., No. 12.

Robins, Philip K. "Federal Support for Child Care: Current Policies and a Proposed New System." In Focus, Vol. II, No. 2, (Summer 1988) Univ. of Wisconsin-Madison.

U.S. Dept. of Commerce, Bureau of the Census. Who's Minding the Kids? Washington, D.C.: 1987.

U.S. Dept of Labor. Child Care: A Workforce Issue. Report of the Secretary's Task Force. Washington, D.C.: 1988.

LACK OF EARLY CHILDHOOD EDUCATION

1. Definition of Problem Area

Low-income children often have problems of poor nutrition, poor health care and social and educational performance which prevent them from achieving their full potential from the beginning of their entry into the public school system. These problems at the start of their school experience significantly reduce the probability that education can help break the cycle of poverty. In response, a range of Federal and State early childhood education programs have been developed to assist disadvantaged children in becoming better prepared for school entry. Head Start is the major preschool program for low-income children under the direction of the Department of Health and Human Services. Thus, this discussion focuses on the performance of the Head Start program in meeting the preschool needs of poor children.

Head Start is a comprehensive child care program serving primarily families whose income is below the poverty level. Services primarily for 3- to 5-year-old children include an education component, in which children attend classes in a center or in which staff conduct regular home visits to children and parents; a health component, ensuring that children are up-to-date in immunizations and have been screened and treated for health and dental problems; and a nutrition component, in which children learn appropriate eating habits and are served nutritious meals and snacks. Services for families include a social services component with a family needs assessment and referrals for services, and a parent involvement component, in which parents are encouraged to become more involved in the process of their child's development. Parents are also encouraged to participate in the direction of their Head Start program.

Head Start began in 1965 as a part of the War on Poverty. Its early programs were usually 6 to 8 weeks long, occurring in the summer before children began school. Today most Head Start programs operate for 8 or 9 months of the year, allowing for more extensive contact between the program staff and families. In center-based options, classes generally operate part-day, from 3 to 6 hours. Head Start is not meant to satisfy day care needs for working parents, and most mothers of Head Start children are not employed.

2. Trends

In the 1987-88 program year, Head Start served a total of 454,000 children. Under the Bush Administration, they have been granted additional expansion monies for 1989-90 which will allow up to 95,000 additional children to be served.

One of the issues faced by the program in its current expansion is the potential competition with other services aimed at the poverty population. For instance, most States use monies from the Social Services Block Grant (SSBG) to support child care for low-income families with employed parents. In some cases these families have

incomes below the poverty level and are eligible for Head Start. But since the Head Start program is usually part-day, some parents forego the extensive services of Head Start in favor of full-time care.

Many States are organizing extensive work-welfare programs in which mothers of preschool children may be asked to join training programs for eventual employment or to begin working. Such programs recognize the need for child care and include some provision for such care. They might encourage parents to use care funded under the SSBG, pay for slots in existing child care facilities, or fund Head Start centers to remain open for additional hours of care.

The Departments of Education in many States or cities are also beginning preschool programs in many elementary schools. In some instances these programs are in low-income neighborhoods and may include children eligible for Head Start. It is relatively rare for schools to coordinate their programs with social service agencies or with Head Start, so a sort of competition for children, teachers, and space may well occur.

3. Number of Children and Families in Need/Service Population

The 1987 Census estimate of the number of 3- to 5-year-old children in the United States living below the poverty level if 2,700,000. Of that number 425,000 or 16% are currently served by Head Start. Using these figures alone, then, it would appear that a very large number of children and families are eligible for, but not receiving Head Start services. (Note that about 35,000 children aged 0-2 and 6 are also served by Head Start.)

In any discussion of "universal" Head Start, however, two caveats are important, each of which reduces the number of children "in need." First, the total number of 3- to-5-year-old children in poverty includes three age cohorts. Most Head Start grantees concentrate their services on children who will enter school next year, rather than spreading their services across all three years of eligible children. They prefer providing services to more children to providing more extensive services to fewer children. If "universal" service were defined as one year of Head Start for as many children as possible, then Head Start would currently be seen to serve about 30% of the eligible children.

Second, as suggested above, there are other educational or child care programs serving this population. Preschools operated by the local school system, SSBG child care centers, or work-welfare child care facilities may not provide all of the services of Head Start, but they do "intervene" in the process of child development for many low-income families. To avoid duplication of services, many Head Start grantees currently supplement the services offered by these groups. This, perhaps, is the optimal approach. We need not count families served by these other programs as "in need of Head Start," but may perhaps consider them in need of "case management."

Unfortunately, no one keeps track on a national level of the number of Head Start-eligible children enrolled in any of the above programs.

Thus, it may not be necessary to aim at serving 100 percent of Head Start-eligible families. If services were to be provided (in most cases) for one year to families who elected to participate, then it may be that simply doubling the size of Head Start would be appropriate.

4. Expenditures

Head Start operates as a Federally funded program with an annual budget in FY 1989 of $1,235,000,000. Approximately $30,100,000 is retained at the national level for training and technical assistance, research and evaluation, and the remaining $1,204,900,000 is granted to operate programs. With 452,314 children estimated to be enrolled in FY 1989, a cost per slot of $2,664 from Federal funds.

One requirement of most Head Start grantees is that 20% of the total budget of the program should be non-Federal share (waivers are sometimes given of this requirement). For some grantees, this contribution is made through State, county or local cash given to the program. For most grantees, free or subsidized space accounts for a portion of the non-Federal share and an imputed value is attached to the hours parents spend in the classroom as teacher aides.

Some States, e.g., Maine and New Jersey, have Head Start-like monies which purchase slots in a program or purchase additional hours of service. No central agency keeps track of these monies; rather, grantees find out about them from their State and apply for them.

5. Cost Per Case

The average Federal cost for Head Start is $2,664, but this number varies widely across grantees. According to the head Start Cost Management System which contains information on the approved budgets of grantees, the grantee with the smallest Federal cost per child receives about $800 per child (supplemented by considerable local resources). The highest cost grantee receives approximately $5,000 per child. The "total" cost per child, including non-Federal share and in some cases a State's contribution, may average over $3,200 per child. Data on this cost are only beginning to be gathered at this time.

In general, center-based programs are more expensive per child per year than are home-based programs (an average of $3,200 vs. $2,400) since home-based programs do not pay as much for space and need not pay for the transportation of children. In terms of costs per hour of service, though, home-based programs are considerably more expensive than center-based programs (about $20.00 in comparison to $5.00), because of the lower number of contact hours in a home-based model.

6. Cost to Address Unmet Service Need

In deciding to double the size of the program (to serve an additional 450,000 children) we may take the average Federal cost per child of $2,664 and calculate a need for $1.2 billion. This assumes, of course, that the cost to serve an additional child is the same as the cost to serve presently enrolled children. This may not be the case.

First, where current grantees can expand services, the cost per additional child may be less. A care of staff already exist. New classes may be added at a marginal cost that is less than the full $2,664. Second, where other programs are providing child care and Head Start may opt to supplement services, the cost per child should be considerably less than the cost for the full complement of services. On the other hand, in counties which are currently unserved by the program, it may be considerably more costly than this average to begin and operate a grantee because of sizeable transportation costs or the need to renovate space completely. It is difficult to balance these estimates in any precise manner.

7. Effectiveness of Intervention

Research on Head Start has shown that the program has powerful short-term effects on children and some positive effects on families. Comparisons of Head Start children with their non-Head Start counterparts show that

- In the year after graduation, Head Start children almost always perform significantly better on intelligence tests than non-Head Start children of a similar age and socioeconomic status;
- In early elementary school, Head Start graduates usually perform better on measures such as teacher ratings, retention in grade and assignment to special education classes;
- Head Start appears to improve the language development of preschool children, though they perform below middle-class controls; and
- Head Start children are healthier than non-Head Start children as a result of the health and nutrition services provided.

Comparisons between Head Start families and others show that

- Head Start programs do assist families in locating needed social services;
- Head Start provides a range of opportunities for parents to become involved with the program and their child's learning and development; and
- Head Start parents report increased feelings of control over their lives, general life satisfaction and increased self-confidence. These feelings increase as their level of involvement in the program increases (CSR, 1983.)

8. Public Opinion

Education, including early childhood education, has consistently been cited as a major concern of Americans today. A June 1988 Gallup poll found that 53 percent of adults were "very concerned" about "a decline in the quality of education in the United States" (Gallup Poll, 1988).

More specifically, another poll conducted prior to the 1988 elections found that 79 percent of American voters felt that "early childhood education programs need more attention and resources under the next president." When asked whether they favored fully funding programs for early childhood education and health, despite budget deficits, versus not increasing spending to reduce the deficit, 60 percent favored increased spending, 20 percent favored reducing the deficit, and 20 percent were not sure. (Peter D. Hart Research Associates, 1988).

References

CSR, Inc. Head Start Research Since 1970. September, 1983.

Gallup Poll. The People, The Press and Politics: Times Mirror Survey III. Princeton, NJ: The Gallup Organization, June 1988.

Peter D. Hart Research Associates. Findings from a National Survey Conducted for KIDSPAC. Washington, D.C.: June 1988.

LACK OF CHILD SUPPORT

1. Definition of the Problem Area

Child support is the economic contribution made by a parent to the living expenses of a child who does not live with the parent, ordinarily because of divorce, separation or out-of-wedlock birth. Either mothers or fathers may be noncustodial parents and pay child support, but nearly all--an estimated 90 percent--noncustodial parents are fathers (Nichols-Casebolt, Garfinkel and Wong, 1988). Both married and unmarried biological fathers may be required to provide child support for their children. Beginning in 1968 the U.S. Supreme Court decided a series of cases which established that illegitimate children are entitled to legal equality with legitimate children under the Equal Protection Clause of the Constitution. These cases established the legal rights of children born out of wedlock to parental support.

2. Trends

The issue of child support is becoming more significant over time because of the increasing number of female-headed families. Since 1960 the number of female-headed families has risen in both absolute terms and as a percent of total families because divorce rates and the proportion of out-of-wedlock births have risen. Since 1960 the number of female-headed families has tripled from 1.9 million to 6 million in 1985 and female-headed families now compose 19 percent of all families with children (U.S. Department of Health and Human Services, Office of Child Support Enforcement, 1988; U.S. Department of Bureau of the Census, 1986). In addition to the 6.0 million female headed-families about 2 million women, currently living with a spouse, have children from a prior marriage or relationship who are legally or potentially due child support from an absent farther. Nearly 45 percent of white children and 86 percent of black children are now expected to spend a portion of their childhoods in families headed by women (Bumpass, 1986). Approximately one out of every two female-headed families has an income below poverty, and a significant factor in this impoverishment is the failure of noncustodial parents to provide child support.

In 1975 Congress added Title IV-D to the Social Security Act because of national concern about the increase in single parent families, their lack of income, and their reliance on public assistance for support. Basic elements of Title IV-D were (1) provision of funds to States to enforce support obligations, to locate absent parents, to establish legal paternity and to obtain support orders, and (2) the creation of the federal Office of Child Support Enforcement (OCSE) to establish standards and to assist States and monitor their performance. The Act also required that, as a condition of AFDC eligibility, all recipients sign over their rights to support to the State and cooperate with the State to establish paternity and secure child support. Non-AFDC families could also receive child support services, but federal incentives were not provided to States for these services.

Title IV-D was amended and strengthened in 1984 to require States to provide child support services to both AFDC and non-AFDC families, to require wage withholding when support payments are in arrears, to establish guidelines for the setting of child support award levels, to expedite processing and the enforcement of interstate claims, and to authorize the use other enforcement methods like the withholding of State and federal income tax refunds, liens on property, posting of bonds and the notification of credit bureaus about child support arrears.

The Family Support Act of 1988 further strengthened child support programs by requiring judges to use State child support award guidelines, by requiring periodic review of these guidelines and periodic review and updating of awards to raise the value of initial awards and to maintain their value over time. In addition States must provide for immediate wage withholding starting in 1994. To enhance paternity establishment and child support enforcement States are also required to collect social security numbers of parents on birth certificate registration forms.

In spite of these programmatic developments, the value of child support awards has decreased over time and compliance rates have remained stagnant. In 1985 the average child support award was $2,495 in contrast to $2,005 in 1978. This represents a 24 percent decline when inflation is factored in (Besharov and Tramontozzi, 1989). Payments on awards have also declined. In 1985 the average amount of child support paid was $2,220 for all women who received some payment; two years earlier the figure was $2,528. Over the two year period payments eroded by 12.4 percent (U.S. Department of Health and Human Services, Office of Child Support Enforcement, 1988).[5] Compliance with child support awards has been relatively stable over the last decade. In 1978, 49 percent of noncustodial fathers paid all of what they owed compared to 48 percent in 1985.

3. Number of Children and Families in Need

In 1986 there were 8.8 million mothers with over 14.8 million children (under age 21) whose fathers were not present in the household. Forty percent of these children (6 million) had no child support awards and the remainder (8.8 million) did. However, in the previous year 1.5 million of children with awards were not due to receive any child support; 1.9 million were due to receive support but received nothing. Only 5.4 million children in mother-headed households (36 percent) received any child support payments in 1985 (calculated using Table 1, U.S. Department of Commerce, 1989). Of this 5.4 million children, 3.5 million received full payment and 1.9 million children received partial payment (calculated using Table 7, U.S. Department of Commerce, 1989).

Not all the 8.8 million women with children under age 21 who were potentially eligible for child support in 1986 needed or wanted assistance in obtaining or collecting that support. The Bureau of the Census estimated that 56% of women potentially eligible for full amount of child support (4.9 million) either were receiving the full amount

[5] Payment and award levels represent all existing awards, not just new awards in the designated years.

of child support (1.0 million) or had awards pending or had made other arrangements, such as joint custody (.5 million). The remaining 3.9 million women either had an award that had not been fully paid (2.2 million) or had wanted, but had not obtained, an award (1.7 million). In 1985, child support due, but not paid amounted to $3.7 billion.

In addition to these mothers, there are those whose child support awards, although fully paid, are insufficient and inappropriate relative to the resources of the noncustodial parent. A recent study using child support award guidelines for three different States (Wisconsin, Colorado, and Delaware) has estimated that noncustodial parents would have paid between $24 and $30 million in aggregate child support payments in 1983 if these guidelines were in force. In contrast, in 1983 noncustodial fathers had child support obligations of $9.7 billion and they actually paid $6.8 billion (Garfinkel and Oellerich, 1989). We are unable to estimate the number of mothers who would fit this category of need because linked data are not available about the financial resources of noncustodial parents.

4. Child Support Expenditures

Between 1976 and 1987, federal spending on child support enforcement went from $139 million to about $745 million. Each year the Office for Child Support Enforcement shows record increases in collections. In fiscal year 1987, the program collected $3.9 billion, a 20 percent increase over the previous year. Total program expenditures (federal and State) in the same year were $1.06 billion resulting in $3.68 collected for every $1.00 spent nationwide.

The fiscal incentives for States in the child support program have meant that the federal costs of the program exceed the federal share of collections realized. In FY 1987 the federal government spent $327 million more than it realized in collections applied to offset its AFDC costs. In other words, the federal government recouped 56 percent of its expenditures on child support through collections. The status of child support enforcement financing is considerable more favorable for the States than for the federal government. When the States share of child support collections on behalf of AFDC recipients is combined with federal reimbursement for child support administrative expenditures and incentive payments, States received in 1987 $349 million more than they spend on child support enforcement program activities. When all levels of government are considered together, the program breaks even when program expenditures ($1.06 billion) are compared to collections that return to the federal and State coffers ($1.08 billion). Beyond these government returns, AFDC families received an additional $279 million through a $50 per month pass-through supplement when child support is collected, and non-AFDC families received $2.5 billion.

5. Cost Per Family

In 1987 the Title IV-D caseload was 10.6 million. Cases are not equivalent to either families or children, but to non-custodial parent/child(ren) units. The caseload figures overestimate the number of families currently in need of support, but data on the

number of families is unavailable.[6] Administrative expenditures for the Office of Child Support Enforcement were $100 per case in 1987. When costs are calculated based on the 1.8 million cases for which a collection was made, the cost per case was considerably higher--$588 per case. The Federal per case cost was $70 for all cases and $414 for cases with collections.

6. Cost to Address Unmet Service Need

There are two aspects of unmet need within the Child Support Enforcement program. The first is the additional cost of increasing the proportion of cases for which a collection is made. Currently collections are made on only 17% of the total child support enforcement caseload. This means that there are no collections for 83% of child support cases because paternity has not yet been established, a support award has not been ordered, or an award is not being enforced. Substantially more resources would have to be spend to increase the proportion of the current case load with collections. At a federal cost of $414 per case with collection, it would take about $1.5 billion more federal dollars to increase the proportion of cases with collections to 50 percent.[7]

The second area of unmet need is women who do not have an award or are not receiving support payment and have not applied for child support enforcement services. Of the 3.9 million mother's who wanted a child support award or were not receiving full payment as the baseline, about 1.3 million were receiving AFDC and, therefore, are included in the child support enforcement caseload of 10.6 million. Additionally, some proportion of the remaining 2.6 million women already have applied for child support enforcement services. This proportion could be tabulated from the 1986 CPS, but is not available in the analysis published by the Bureau of the Census.

7. Effectiveness of Intervention

Research to date suggests that child support program practices are related to child support payment patterns. Participation in the Child Support Enforcement Program has been found to have a significantly positive effect on the receipt of child support (Robbins, 1986; Sonenstein and Calhoun, 1988) and residents of States using strong enforcement irremediableness, expedited administrative procedures, and wage-withholding--receive higher payments holding constant the effect of custodial mother characteristics (Beller and Graham, 1984; O'Neill, 1985). There is also some evidence that the use of guidelines to set child support awards increases their levels (Sonenstein and Calhoun, 1988). Currently the Office of Child Support Enforcement is evaluating the impact of the 1984 Amendments.

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[6] The CSE caseload count overestimates the number of families because it includes more than one non-custodial parent, multiple cases for the same child(ren) when more than one putative father has been identified and paternity has not yet been adjudicated, and cases where no current support is due but support payments are due the state to offset past AFDC payments made to the family.

[7] A collection rate of 50% would require that a collection would be made on one-half of the current caseload of 10.6 million cases, or 5.3 million cases. This would be an increase of 3.5 million cases times a Federal cost per case of $414.

8. Public Opinion

In 1975 when the originating federal child support legislation was passed there was a substantial controversy over the appropriate role of the federal government. Concern was expressed both about federal usurpation of the States' traditional jurisdiction in family law and about the families right to privacy. While all issues regarding privacy and state jurisdiction have not been resolved, the general public, the Congress, and federal and State governments continue to support ongoing efforts to improve the financial security of children through the payment of child support. While the goal of providing child support for all children with a parent absent from the home is almost universally accepted, there is not unanimity about how to best achieve this goal. Major areas of concern include the relationship between child support and custody and visitation agreements, equity in the treatment of custodial and non-custodial parents in establishing and updating awards, the impact of second families on the establishment of awards and the expansion of targeted child support services to a universal entitlement.

References

Beller, A.H. and Graham, J.W. "The Effect of Child Support Enforcement on Child Support Payments." Paper presented at the Population Association of American Annual Meetings, Chicago, May 2, 1087.

Besharov, D.J. Seven Key Issues for Child Support Research: Results of a Joint AEI/HHS-ASPE Conference. Washington, D.C.: American Enterprise Institute. May, 1989.

Bumpass, L. Children and Marital Disruption: A Replication of Update. Demography, 21 (1): 71-82, 1984.

Garfinkel, I. and Oellerich, D. Noncustodial Father's Ability to Pay Child Support. Demography, 26 (2): 219-234, 1989.

Nichols-Casebolt, A., Garfinkel, I., and Wong, P. "Reforming Wisconsin's Child Support System." In S. Danziger and J. Witte (eds.) State Policy Choices: The Wisconsin Experience. Madison: University of Wisconsin Press, 1988.

O'Neill, J. Determinants of Child Support. Final Report under Grant No. 1 R01 HD 16840-01, National Institute of Child Health and Human Development. Washington, D.C.: The Urban Institute, 1985.

Robins, P.K. "Child Support, Welfare Dependency and Poverty." American Economic Review, 76 (4): 768-788, 1986.

Sonenstein, F.L. and Calhoun, C.A. "Survey of Absent Parents: Pilot Results." Washington, D.C.: The Urban Institute, 1988.

U.S. Department of Commerce, Bureau of the Census. Child Support and Alimony: 1985. Current Population Reports, Special Studies, Series P-23, No. 154. U.S. Government Printing Office 1989.

U.S. Department of Commerce, Bureau of the Census. Household and Family Characteristics: March 1985. Current Population Reports, Population Characteristics, Series P-20, No. 4. U.S. Government Printing Office, Washington D.C., 1986

U.S. Department of Health and Human Services, Office of Child Support Enforcement. Child Support Enforcement: Twelfth Annual Report to Congress. Vols. 1 & 2, 1988.

HOMELESSNESS

1. Definition of the Problem Area

This paper adopts the definition of a homeless person that is used in P.L. 100-77, the Stewart B. McKinney Homeless Assistance Act, enacted in July 1987. Individuals are considered homeless if they lack a fixed, regular, and adequate nighttime residence or if their primary nighttime residence is a shelter designed to provide temporary living accommodations, an institution providing temporary residence for individuals intended to be institutionalized, or a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings.

Homelessness takes several forms. The Institute of Medicine distinguishes between temporary homelessness, episodic homelessness and chronic homelessness. Temporary homelessness occurs when people are displaced by calamities such as fires or evictions. If local employment and housing conditions are favorable, individuals may be rehoused relatively quickly. However, reintegration is sometimes difficult and may be compounded by secondary factors like loss of a car, family breakup or depression. Episodically homeless people go in and out of homelessness. Individuals or families move along with relatives or friends may experience homelessness in between. Other individuals living on fixed incomes may rent housing on a weekly basis, may be out of money and out of shelter before the month is over. The majority of the homeless fall into the temporary or episodic categories (Institute of Medicine, 1988). In 1988, about one-half of the sheltered population on a single night were estimated to have been homeless for less than 3 months (U.S. Department of Housing and Urban Development, 1989; Urban Institute, 1987). On the other hand, one-quarter were estimated to have been homeless for more than 3 years (U.S. Department of Housing and Urban Development).

2. Trends

By many accounts, the number of homeless people has grown appreciably in recent years. Surveys conducted by the U.S. Conference of Mayors in 25 representative cities in each of the past 2 years show that most cities reported annual increases of 15 to 50 percent. However, more rigorous research efforts suggest that the growth rate is lower, probably about 10%. A substantial majority of the cities report that families are the fastest growing segment of the homeless population (U.S. Conference of Mayors, 1987 cited in Institute of Medicine, 1988).

The following factors are believed to have contributed to the growth in homelessness: (1) a shortage of low-income housing, (2) changing economic trends and inadequate income supports, and (3) the prevalence of mental illness among the homeless (estimated by NIMH to be about 33% of the homeless population).

Since 1980 the aggregate supply of low-income housing has declined by 2.5 million units. Concurrently, half the national total of SRO housing (Single Room

Occupancy) has been lost to conversion or demolition since 1970. The GAO estimates that 900,000 subsidized low-income housing units will disappear from the low-income housing market and return to the open market by 1995. The housing shortage has been accompanied by a rise in the relative price of remaining units and a rise in the proportion of income which must be devoted to the purchase of shelter (U.S. Census Bureau, American Housing Survey, 1985). In 1974 median rent paid by poor families made up 35 percent of their income; in 1985 it was 65 percent of income. The situation is worse for single parent households; in 1983 one-third of these families were paying more than 75 percent of their income on rent (Brown and Yinger).

Between 1973 and 1984 the number of people in poverty in the U.S. rose from 23 million to 34 million. Welfare programs such as AFDC and general assistance programs have not kept pace with inflation. Between 1970 and 1985, median AFDC benefits nationwide declined by about one-third in real dollars. General assistance benefits declined by one-third during the 1970's (Institute of Medicine, 1988).

The populations of public mental hospitals fell from a high of 559,000 in 1955 to a low of 130,000 in 1980. But the mental health system is not the only one to transfer clients to community-based services, nor is it clear how many of those leaving State hospitals became homeless. The criminal justice system, the mental retardation system and the foster care system all discharge young people when they age out of the system even when there is nowhere to live (Institute of Medicine, 1988).

3. Number of Children and Families in Need/Service Population

Based on State-reported data, a recent GAO report estimates that, at a given time, about 68,000 children 16 years old or younger are homeless and 186,000 are precariously sheltered in shared housing. Of these, roughly 25,000 are housed in shelters or hotels and 4,000 in churches. Perhaps the most disturbing statistic is that about 9,000 children are estimated to stay in public places, such as cars, abandoned buildings, bus terminals, etc. Roughly 8,000 are housed in other facilities, such as spousal abuse centers, detoxification cells or jails. Over the course of a year, about 300,000 youth are estimated to receive services from shelters or voucher providers (General Accounting Office, 1989). The GAO estimates were relatively consistent with other data sources.

In late 1987 based on a national sample, the Urban Institute estimated that families with children made up 23 percent of all homeless people among the service-using homeless population in cities of 100,000 or more. Most homeless families are headed by women with two or three children (Bassuk et al., 1986). Most of the children are under the age of 5 and are spending their critical developmental years without the stability and security of a permanent home. Homeless children have been found to have poor school attendance, more health problems, and lower rates of immunization (Institute of Medicine, 1988).

While the majority of homeless families are headed by women, the proportions vary by geographic region of the country. In the West there are more 2-parent homeless families. The number of homeless families that are recipients of AFDC is unclear. The 1987 Urban Institute study estimated that 33% of service-using homeless families were AFDC recipients. A Massachusetts study indicated that long-term recipients are over-represented among homeless families (Bassuk et al., 1986). Researchers have reported that homeless mothers typically are quite isolated and have few supportive relationships. Many homeless mothers are victims of family violence. In Massachusetts 45 percent of a sample of women in family shelters had a history of an abusive relationship with a spouse or mate; 22 percent of the sample were involved in an investigation of follow-up of child abuse and neglect (Bassuk et al., 1986). A national sample of family shelter managers in 1988 reported that about half their adult clients had been involved in domestic violence, about 12 percent were mentally ill and 20 percent had alcohol problems (U.S. Department of Housing and Urban Development, 1989). A substantial proportion of homeless families using the sheltering system can be characterized as multiproblem families. These families have chronic economic, educational, vocational, and social problems, have fragmented support networks; and have difficulty accessing the traditional service system (Institute of Medicine, 1988).

4. Program Expenditures

A 1988 National Survey of Shelters for the Homeless (U.S. Department of Housing and Urban Development, 1989) shows that the number of homeless shelters in the U.S. has tripled since 1984, and that the money spent annually to provide shelter has increased fivefold over this period. In 1988, it was estimated that there were 5,400 shelters with a 275,000 bed capacity in the U.S. compared to 1,900 in 1984 with a 100,000 bed capacity. Two out of every 3 beds was occupied on an average night in 1988, an occupancy rate similar to the 1984 rate. However, occupancy rates are seasonal with high occupancy during adverse weather and low occupancy in milder conditions.

In 1988 more than one-third of all shelter served families with children with a 58,300 bed capacity. Another 25 percent of the shelters served unaccompanied men with an estimated 89,100 beds and 39 percent of the shelters served other populations with an estimated 124,254 beds. In the past the country's shelter system has been criticized for being organized exclusively to serve adult individuals. This is less true in recent years. Families are rapidly becoming major users of homeless shelters. In 1988, 40 percent of the sheltered homeless were family members compared to 21 percent in 1984. Three-quarters of sheltered families are composed of single parents with children, with the remainder almost equally divided between couples with and without children.

A large proportion of shelter services relies on the efforts of volunteers (Institute of Medicine, 1988). Ninety percent of shelters are operated by private, non-profit groups aided by volunteers. Two-thirds of the funding comes from local, State and federal governments.

In 1988 the nation's shelter managers estimated that $1.5 billion was spent on shelters nationwide, compared to $300 million in 1984. Approximately two-thirds of the 1988 shelter revenues came from a variety of federal, State and local government sources including the Federal Emergency Management Agency's Food and Shelter Program, HUD's Emergency Shelter Grant and Community Development Block Grant programs, and HHS's Community Services Block Grant program. In contrast, one one-third of shelter revenues came from public sources in 1984. Private contributions, although proportionately less of the total, more than doubled since 1984.

Federal legislation has provided a program of emergency assistance to families receiving AFDC who are temporarily displaced from their usual living arrangements. AFDC special needs and AFDC emergency assistance have become the primary mechanisms for financing family shelters and supportive services in many communities, largely through payments for hotel and motel rooms or similar accommodations. These funds can only be used for relatively short-term crises and not for permanent housing. Thirty states have elected to have emergency assistance programs with an average monthly caseload of 46,185 and Fiscal Year 1988 expenditures of $21 million (Committee on Ways and Means, 1989).

The major homeless aid bill of the 100th Congress, the Stewart McKinney Homeless Assistance Act of 1987, was signed into law on July 23, 1987. IN FY88 $362.5 million was appropriated under this act: including $114 million for FEMA's (Federal Emergency Management Agency) emergency food and shelter program, $8 million for HUD's State grants for emergency shelter, $49 million for a supportive housing demonstration program, $15 million for HUD's permanent housing for the handicapped, $14 million for outpatient health care for the homeless through HHS, $19 million for HHS's Community Service Grants for the homeless, $11.5 million for HHS mental health demonstration grants, $7 million for the Department of Education for literacy programs for the homeless, $5 million for education programs for homeless school children, $2 million for veteran's job training, $7.7 million for job training demonstrations, $59 million for food stamps, and $50 million for temporary emergency food assistance programs (National Coalition for the Homeless, 1988). The FY 1990 Bush budget request was close to $1 billion.

5. Cost Per Family

The average cost per person, per night, for shelter services for family members was $29 in 1988 (U.S. Department of Housing and Urban Development, 1989). However, the costs vary dramatically depending on services provided by the shelter and supportive services. For example, the GAO reported the cost per person for transitional shelter in New York City was $69 per night.

In 1986 the Commonwealth of Massachusetts paid between $1,350 and $1,600 per month per family for emergency assistance housing (Institute of Medicine, 1988).

6. Cost to Address Unmet Service Need

Assuming, conservatively, that only the 9,000 children sleeping in public places need shelter facilities (along with their parents or guardians) and that there are 2 children per family, it is estimated that $48 million per year is needed to shelter those currently without facilities. Providing services to those in suboptimal shelter, such as those living doubled up with relatives, would multiply these costs. However, shelters would be hard pressed to open slots only to children and their families and to reject single adults. Thus, a higher level of funding would be needed to increase capacities adequately for children. More comprehensive services and/or efforts to make rental housing more affordable could have costs into the billions of dollars.

It should be noted that a recent HUD survey indicated some excess shelter capacity on some nights for shelters accepting families. Also, there is seasonal variation in shelter need.

7. Effectiveness of Intervention

No evaluations were identified. Since the primary goal is short-term shelter, current interventions probably meet this need. However, media reports indicate that shelters are often substandard, especially from the perspective of the needs of young families.

8. Public Opinion

In the past few years, homelessness, along with the related issues of poverty and hunger, have appeared on pollsters' lists of the social problems most frequently mentioned as a serious domestic problem. Homelesness, along with poverty and hunger, frequently appears as second to drugs as a leading concern of Americans. In recent Gallup and Washington Post/ABC polls, about 10 percent of the public cited homelessness, poverty and hunger as the nation's biggest problem, twice as high as a few years ago (Morin, 1989). Further, the public appears to believe that conditions have not improved or is uncertain that the government knows how to solve the problems of poverty ("Poverty is Perceived as Increasing," 1989).

Nonetheless, the public believes that government should play a role. A majority (54 percent) of voters surveyed in June 1988 said they would be "much more likely" to support a Presidential candidate who supports "more financial assistance for the homeless and those truly needy who cannot afford basic necessities, like food, clothing and shelter." Seventy-nine percent said they would "probably support" higher taxes to pay for such assistance, but slightly under half (42 percent) said they would "definitely support" higher taxes for these purposes (Gallup Poll, 1988).

References

Bassuk, Ellen and Lenore Rubin. "Homeless Children: a Neglected Population." American Journal of Orthopsychiatry, Vol.57, No.2, April 1987.

Burt, Martha R. and Barbara Cohen. "Review of Research on Homeless Persons." Washington, D.C.: The Urban Institute, September 1988.

Brown, H. James and John Yinger. Communication to the Children's Defense Fund. Cambridge, Mass.: Joint Center for Housing Studies of MIT and Harvard University.

Children's Defense Fund. A Vision for America's Future. Washington, D.C., 1989.

Committee on Ways and Means. Background Material and Data on Programs within the Jurisdiction of the Committee on Ways and Means: 1989 Edition. Washington, D.C.: Govt. Printing Office, 1989.

Gallup Poll. AARP Survey of Family Issues: Analytical Report, Princeton, NJ: Gallup Organization, June 1988.

Institute of Medicine, Committee on Health Care for Homeless People. Homelessness, Health and Human Needs. Washington, D.C.: National Academy Press, 1988.

Molnar, Janice, Tovah Klein, Jane Knitzer, and Blanca Ortiz Torres. Home is Where the Heart is: The Crisis of Homeless Children in New York City. Bank Street College of Education, March 1988.

Morin, R. "Drug Abuse Leads the Nation's Worries." Washington Post, August 23, 1989.

National Coalition for the Homeless. Necessary Relief: The Steward B. McKinney Homeless Assistance Act. Washington, D.C.: The National Coalition for the Homeless, June 1988.

"Poverty is Perceived as Increasing and State of the Poor Unimproved." New York Times, August 23, 1989.

U.S. Conference of Mayors. The Continuing Growth of Hunger, Homelessness and Poverty in America's Cities: 1987 December, 1987.

U.S. Department of Housing and Urban Development. A Report on the National Survey of Shelters for the Homeless. March, 1989.

U.S. General Accounting Office. Children and Youths: About 68,000 Homeless and 186,000 in Shared Housing at Any Given Time. GAO/PEMD-89-14, June 1989.