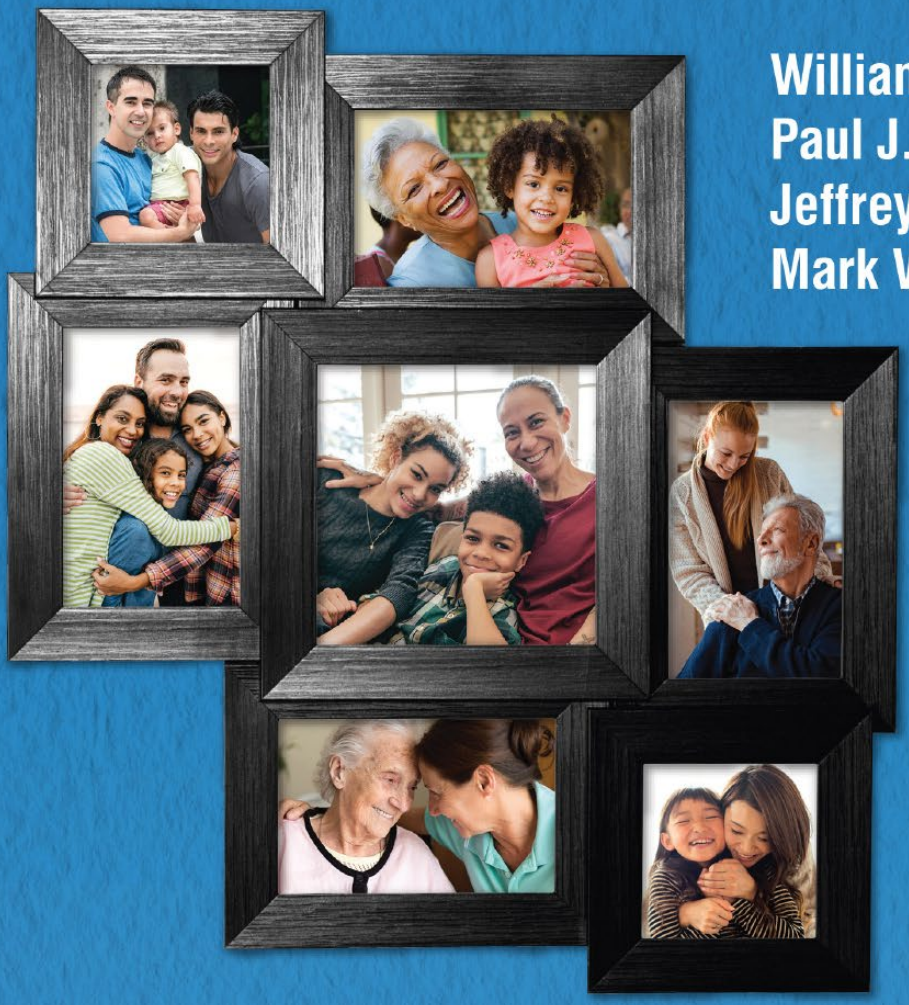

William James Hall III
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Mark W. Fraser

Social Policy for Children & Families

A Risk and Resilience Perspective | 4TH EDITION

Social Policy for Children and Families

Fourth Edition

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A Risk and Resilience Perspective

Fourth Edition

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CONTENTS

ACKNOWLEDGMENTS

The ideas expressed in the fourth edition of this volume address many of the most pressing problems confronting children, youth, and families in American society. We thank each of the chapter authors for providing important new information about innovative approaches to social policy in their respective service system domains. Each author's commitment to expanding the application of evidence and principles of risk, protection, and resilience to the design, implementation, and evaluation of social policies for young people and their families is exemplary.

—William J. Hall
—Paul Lanier
—Jeffrey M. Jenson
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INTRODUCTION

Nelson Mandela once said, "There can be no keener revelation of a society's soul than the way in which it treats its children" (Nelson Mandela Children's Fund, 2015). Children and youth have fewer rights than adults and depend on parents, caregivers, and other responsible adults for their universal human needs. Indeed, children are among the most vulnerable members of society, navigating formative periods of development in a world constructed and administered by adults. Childhood and adolescence are profound periods of biophysical, psychological, and social development that have long-term implications for health and social well-being into adulthood.

Unfortunately, there is good reason to be concerned about the status and future of American children and youth. They are more likely than any other age group to be poor. Too many children are neglected and subject to abuse and violence. Young people face significant educational, mental, behavioral, and health challenges amid under-resourced and fragmented service systems. Homicide, suicide, and unintentional injury are the leading causes of death for children and adolescents in the United States (National Center for Injury Prevention and Control, 2019). It is the responsibility of all adults in America, especially those in positions of power and influence, to help secure a better society for our young people.

This book aims to inform readers about the policy strategies necessary to tackle the most complex and pressing health and social problems facing American children, youth, and their families. We argue that a person-in-environment and risk and resilience perspective is the best way to approach this work. Begun some 40 years ago, research to trace the causes of social and behavioral health problems facing young people has led to new understandings of the individual, interpersonal, and environmental factors that affect developmental and, indeed, life course outcomes. In the past two decades, attention has been directed to increasing our understanding of the concept of *resilience*, which is the process through which children overcome adverse life circumstances (Fraser et al., 2004). In recent years, knowledge of risk and resilience has been widely used to develop and improve the efficacy of prevention and treatment programs for vulnerable children and families (e.g., Catalano et al., 2012; Jenson & Bender, 2014). Nonetheless, widespread implementation of preventive interventions remains elusive. Even worse is the inadequate application of evidence about risk, protection, and resilience to the design of social policies. National, state, and local policies have the capacity to transform service systems and influence the lives of millions of Americans in ways that promote resilience and well-being. But often, this capacity is unrealized.

The United States has one of the most diverse populations in the world, yet it also has a troubled legacy of racism, economic inequality, and other forms of oppression. Social policies and intervention programs must aim to ameliorate the disparities and inequities that burden marginalized young people and their families and communities.

To neglect such efforts would represent a failure of our core American values of equality, cooperative progress, and liberty, and even worse, it would tacitly represent the support of preventable harm and suffering, the denial of basic human dignity, and the blocking of opportunities for all of our children and youth to fully realize their potentials. We discuss the importance of applying principles of anti-oppression in Chapter 1.

Progress toward improving mental, behavioral, educational, social, and health outcomes for young people can be achieved in the foreseeable future. Through a person-in-environment and risk and resilience perspective, as well as an anti-oppression perspective, we can conceptualize the multiple and interacting factors from all levels of society that shape outcomes and developmental trajectories for young people. By applying principles of anti-oppression and knowledge of risk, protective, and promotive factors to the design of social policy, we can significantly impact the continuum of programs, practices, and services for children, youth, and families. We hope that this book will help students, practitioners, policymakers, and researchers achieve this collective goal to promote child health and social well-being.

ORGANIZATION OF THE BOOK

The core section of the book is formed by 10 chapters devoted to policies intended to address poverty, child welfare, education, mental health, health, developmental disabilities, substance abuse, immigration, juvenile justice, and gun violence. Chapter authors identify key policies in their respective areas and evaluate the extent to which evidence of risk, protection, and resilience can be used to improve policies, programs, practices, and services. Recommended readings, questions for discussion, and Web-based resources are provided. Authors follow a similar outline in which they

- provide an overview of the purpose or goals of social policy in a substantive area;
- describe the incidence and prevalence of problems affecting children, youth, and families, including disparities and inequities;
- outline prominent risk and protective factors associated with the onset or persistence of the problems identified;
- discuss historical and current policies that have been developed to address these problems;
- evaluate the extent to which policies have been based on evidence about risk, protection, and resilience;
- provide recommendations for improving policies, programs, practices, and services that incorporate research regarding risk, protection, and resilience; and
- discuss ways to integrate programs and services across policy domains or service systems.

Poverty is a foundational problem connected to every substantive problem discussed in this book. In Chapter 2, Trina Williams Shanks, Sandra Danziger, and Patrick Meehan analyze poverty trends and examine contextual risks and protective factors associated with earning a low income at the family and community levels. They critically assess past and current programs and policies intended to reduce and prevent child and family poverty. Recommendations for poverty-alleviating strategies for children, families, and communities are identified.

In Chapter 3, Michelle Johnson-Motoyama, Jill Duerr Berrick, and Andrea Lane Eastman describe American child welfare policies and programs intended to respond to children's need for protection from abuse or harm from their caregivers. In addition to describing the key elements and processes of the child welfare system, the authors also offer suggestions for policies, programs, and practices to prevent child maltreatment and improve services for children and families involved in this key service domain.

In Chapter 4, Andy Frey, Myrna Mandlawitz, Armon Perry, Hill Walker, and Brandon Mitchell focus on school dropout and failure. In addition, they identify risk and protective factors associated with school adjustment and academic achievement. They note that public education policy is closely linked to political ideology and societal values as they outline the development of education policy from its beginning to the current era, which is dominated by the No Child Left Behind Act. They conclude by offering recommendations for education policies and programs based on principles of risk, protection, and resilience.

In Chapter 5, Paul Lanier, Megan Feely, and Mary Fraser review epidemiological research on the scope and burden of child and adolescent mental disorders. They focus on individual, family, and environmental risk and protective factors for behavioral health problems. They describe policies designed to improve access to services for children and youth with mental disorders, including community mental health centers and systems of care.

In Chapter 6, William Hall, Hayden Dawes, Alexandria Forte, Luke Hirst, and Danny Mora trace the development of key public health and health care policies pertaining to infants, children, adolescents, and their parents up to the implementation of the Patient Protection and Affordable Care Act. They discuss prominent and preventable health problems facing young people, including low birth weight, asthma, obesity, sexually transmitted infections, suicide, and COVID-19. Hall and colleagues conclude with a critical appraisal of the American health care system, evidence-informed recommendations to improve the system, and illustrative examples for the integration of health care with other services and resources.

The proportion of children with a developmental disability has increased in recent decades. In Chapter 7, Kiley McLean, Meshan Adams, and Lauren Bishop discuss risk and protective factors for poor outcomes among children with disabilities and their families, including adversities due to systems of oppression. They analyze policies and programs pertaining to education, civil rights, health care, and income for young people with disabilities. Using principles of risk, protection, and resilience, McLean and her colleagues offer policy recommendations for improving services and promoting inclusion, resilience, and quality of life for children and youth with developmental disabilities.

In Chapter 8, Elizabeth Anthony, Jeffrey Jenson, and Matthew Howard review current trends in the prevalence, disparities, etiology, prevention, and treatment of adolescent substance abuse. The authors trace the origins of policies aimed at the prevention and treatment of substance abuse and comment on the relative effectiveness of alternate policy approaches. Anthony and colleagues conclude that principles of risk, protection, and resilience have been influential in improving the efficacy of prevention and treatment programs for young people and reflect on the implications of these findings for substance abuse policy.

The United States was established and transformed by immigrants, yet social policies and public systems often fail to meet the needs and challenges of immigrant groups. In Chapter 9, Megan Finno-Velasquez, Anayeli Lopez, Sophia Sepp, and Marianna Corkill describe present-day immigrant children and families. They provide a comprehensive discussion of federal immigration policy, including pathways to residency and citizenship, and the ways that policies create inequitable access to public assistance, early childhood programs, health care, and mental health services for immigrant children and families.

In Chapter 10, Amy Blank Wilson, Jonathan Phillips, Melissa Villodas, Anna Parisi, and Ehren Dohler trace the evolution of juvenile justice policy from the creation of the first juvenile court to the current era of evidence-based practice. They describe key decision points in the juvenile justice system, strategies to reduce youth contact with the system, and opportunities to address disparities and inequities related to race/ethnicity, gender, and sexual orientation.

In Chapter 11, Chris Rees and Eric Fleegler provide an overview of gun ownership in the United States and describe the epidemiology of firearm homicides and assaults, firearm suicides, unintentional firearm injuries, and school shootings. They also discuss prevention strategies to reduce firearm-related injuries and fatalities.

In the final chapter of the book, we expand on our framework for using principles of risk, resilience, and anti-oppression to develop more fully integrated policies for children, youth, and families. We argue that integration of policy and programs across service domains should be a goal of future policy directives targeting children, youth, and families. Consideration is given consistently to child developmental processes and research in the design of this framework. Recommendations for ways to advance principles of anti-oppression and promote a public health social work framework based on risk, protection, and resilience in policy design, implementation, and evaluation are offered.

SUMMARY

We hope that the interdisciplinary framework described in this book stimulates innovative ideas about the design of policies for vulnerable children and families. Principles of anti-oppression and of risk and resilience—too often ignored in policy discussions—hold great promise for improving the reach and effectiveness of social policies. We believe that an increased focus on these principles will lead to policies that will improve the health and well-being of all children and families.

REFERENCES

Catalano, R. F., Fagan, A. A., Gavin, L. E., Greenberg, M. T., Irwin, Jr., C. E., Ross, D. A., & Shek, D. T. (2012). Worldwide application of prevention science in adolescent health. *Lancet*, *379*, 1653–1664.

Fraser, M. W., Kirby, L. D., & Smokowski, P. R. (2004). Risk and resilience in childhood. In M. W. Fraser (Ed.), *Risk and resilience in childhood: An ecological perspective* (2nd ed., pp. 13–66). NASW Press.

Jenson, J. M., & Bender, K. A. (2014). *Preventing child and adolescent behavior. Evidence-based strategies in schools, families, and communities*. Oxford University Press.

National Center for Injury Prevention and Control. (2019). *10 leading causes of death by age group, United States—2018*. Centers for Disease Control and Prevention.

Nelson Mandela Children's Fund. (2015). *Nelson Mandela quotes about children*. https://www.nelsonmandelachildrens-fund.com/news/nelson-mandela-quotes-about-children

1

A MULTISYSTEMS RISK AND RESILIENCE APPROACH TO SOCIAL POLICY FOR CHILDREN, YOUTH, AND FAMILIES

William J. Hall, Paul Lanier, Jeffrey M. Jenson, and Mark W. Fraser

Social, political, and economic events of the past several years have had a significant and adverse impact on the lives of young people and their families. While such events have led to a reduction in the provision of family-based programs and policies, they have also afforded a unique opportunity to find new and innovative ways to promote positive outcomes for children, youth, and families. As a result of elections that alter political leadership, events that galvanize public opinion (e.g., pandemics, deadly shootings, and wildfires), and scientific advances that affect our knowledge of social and health problems, we often have opportunities to craft social policies to more proactively and systematically promote the safety, health, and social well-being of young people and their families. As this book describes, significant gains have been made in understanding the individual, family, community, and broader social factors—such as racism and other forms of oppression—that influence child and adolescent developmental outcomes, including high school graduation and, in the long run, labor market participation. Through evaluations, randomized trials, and qualitative studies, we have also learned a great deal about the effectiveness of social policies and programs intended to prevent problems and promote healthy outcomes in children and families. If this knowledge were to be more purposively incorporated in social policy, we would have increased potential to produce healthy development in young people. Yet, current United States (U.S.) social policy and, indeed, policies across the globe are too often characterized by reactive and piecemeal efforts that only shore up under-resourced and fragmented service systems. Today's children and youth face numerous threats—from gun violence to extreme poverty—that are highly preventable through more strategically designed policies, evidence-informed interventions, and efficient, coordinated, and well-resourced service systems. This book aims to inform the current debate about the best way to support children and parents and to provide evidence supporting effective policy approaches that lead to healthy development in young people.

GROWING UP IN AMERICA: THREATS AND OPPORTUNITIES

Children, youth, and families face enormous challenges in American society. At no time in the country's history have young people and their parents been confronted simultaneously by such a wide array of influences and opportunities. Most children and youth become healthy adults who participate in positive and prosocial activities guided by interests that lead to meaningful and fulfilling lives. However, for some children and youth, the path to adulthood is a journey filled with risk and uncertainty. Because of the adversities these young people face, the prospect of a successful future is often bleak.

If we were to draw a picture depicting the current status of America's children and youth, it would be a portrait of contrasts. Despite being the most economically prosperous country in the world (Organisation for Economic Co-operation and Development, 2020), 16% of children (ages 0–18) in the U.S. live in poverty (Semega et al., 2020). Poverty is related to many health and social problems. Even as society venerates them, children are more likely than all other age groups to be poor. Moreover, young people of color are disproportionately represented in poverty (Children's Defense Fund, 2020). Recent data indicate that 30% of African American, 29% of American Indian, and 24% of Hispanic/Latinx children live in conditions of poverty. Those rates are more than double the poverty rates for Asian (11%) and White (9%) children.

Two thirds of recent high school graduates enroll in colleges or universities (U.S. Bureau of Labor Statistics, 2020a), and the U.S. leads the world in higher education (Quacquarelli Symonds, 2019; Williams & Leahy, 2019). Unfortunately, education as a means to socioeconomic advancement is often blocked for those youth who experience early academic failure or drop out of school. Data show that 2.1 million youth age 16 or older dropped out of school in the 2017–2018 academic year, failing to earn a high school diploma or GED (general equivalency diploma) certificate (Hussar et al., 2020). The overall school dropout rate was 5.1% in 2017–2018; however, American Indian (9.5%), Pacific Islander (8.1%), Hispanic/Latinx (8.0%), and Black (6.4%) youth had higher dropout rates than White (4.2%) and Asian (1.9%) youth.

On a positive note, nearly 30% of high school–age youth volunteer in social causes, a number that has increased significantly in recent decades (Grimm & Dietz, 2018). Other data reveal promising behavioral trends, including a reduction in the prevalence of some problem behaviors. Notably, violent offending among youth rapidly increased between the late 1980s and mid-1990s, but rates of juvenile violent crime have declined significantly since, reaching a historically low level in 2018 (Jenson et al., 2001; Puzzanchera, 2020). Juxtaposed against this promising news are the disturbing accounts of school shootings. There were 66 school shootings with casualties at K–12 schools in 2017–2018 (Wang et al., 2020). School violence is widespread—over 70% of U.S. public schools recorded at least one violent incident in the 2017–2018 school year. The deaths of 20 first-grade children and six educators at Sandy Hook Elementary School in Newtown, Connecticut, in 2012 and the deaths of 14 high school students

and three educators at Marjory Stoneman Douglas High School in Parkland, Florida, in 2018 were jolting reminders that students and educators are not always safe in their own schools and communities. Indeed, homicide is the fourth leading cause of death among children and youth ages 1 to 19 in the U.S. (Centers for Disease Control and Prevention [CDC], 2019).

Threats and opportunities for children and youth are not merely social in nature. Approximately one quarter of U.S. land and marine areas are designated as protected or conservation areas (Protected Planet, 2020), and young people and their families have access to thousands of national, state, and local public parks. These spaces provide opportunities for physical activity, social connection, and psychological restoration as well as decrease noise and air pollution. Regrettably, green spaces also face human-caused threats. The U.S. is second only to China in global CO_2 emissions (International Energy Agency, 2020), and the U.S. is the biggest generator of waste per capita worldwide (Kaza et al., 2018). Many young people are living in areas with unhealthy ozone or particle pollution and high exposure to toxic chemicals, which threaten their health (American Lung Association, 2020; Landrigan & Goldman, 2011). Fortunately, awareness and concern about climate change has risen sharply in the past decade, particularly among young people (Reinhart, 2018; Saad, 2019; Scanlon, 2019). Regrettably, policies aimed at climate change have lagged behind levels of public awareness (Mason & Rigg, 2018).

In 2020, children, youth, and families were confronted with a pandemic due to the global outbreak of the novel coronavirus. Although children and youth currently make up a very small proportion of deaths from the coronavirus (CDC, 2020), their lives have been greatly affected by the illness. They have lost family members, friends, and neighbors; and they have experienced the closure of their schools, playgrounds, and other gathering spaces for social, educational, recreational, and cultural activities. Public health experts have raised serious concerns about the cascading effects of the coronavirus on family functioning and on socioemotional development (Family Health in Europe–Research in Nursing Group, 2020; Fegert et al., 2020; Fraenkel & Cho, 2020). The novel coronavirus and the conditions associated with it present new and heightened challenges for shaping social policies aimed at promoting healthy youth development.

AMERICA'S DIVERSE FAMILIES

While complicating from an intervention standpoint, the diversity of American families offers significant strengths in building healthy and resilient youth. The U.S. is perhaps the most diverse nation on Earth—a rich and colorful tapestry of cultures, identities, social groups, and family backgrounds. In its beginning, what is now the U.S. had been a home to hundreds of indigenous cultural groups; it is estimated that as many as 500 languages were spoken by Native Americans prior to 1492 (National Museum of the American Indian, 2007). After centuries of colonization, immigration,

and forced displacement, the U.S. population reflects many hundreds of ethnic groups from origins across the globe (U.S. Census Bureau, 2007). The racial diversity of America continues to expand; currently, 60% of the population is classified as White, 18% as Hispanic/Latinx, 13% as Black/African American, 6% as Asian, 3% as multiracial, and 1% as Native American (U.S. Census Bureau, 2019). It is estimated that by 2045, people of color will make up a numerical majority of the population (Vespa et al., 2020). Due to a function of worldwide migration, the U.S. has more immigrants than any other nation; immigrants make up 14% of the U.S. population (Budiman, 2020). The legal status of immigrants varies, with 23% being undocumented, 27% being lawful permanent residents, 5% being temporary residents, and 45% being naturalized citizens.

Despite being the most economically prosperous country, there is significant stratification in socioeconomic status in the U.S., often falling along racial/ethnic lines and immigrant and citizenship status. In 2018, the median household income was approximately $63,000, with the average American household consisting of 2.5 people (Semega et al., 2020). Income-based analyses classify 20% of Americans as lower income, 9% as lower-middle income, 50% as middle income, 12% as upper-middle income, and 9% as high income, with associated median household income ranges for a family of three as follows: ≤ $31,000 (lower income); $31,000–$42,000 (lower-middle income); $42,000–$126,000 (middle income); $126,000–$188,000 (upper-middle income); and ≥ $188,000 (high income; Pew Research Center, 2015b).

The structure and composition of families has shifted in recent decades, expanding from traditional social norms and ideals. Today, less than half of children are raised by two parents in a first marriage (Pew Research Center, 2015a). Increasingly, children are growing up in family arrangements that include single-parent families, unmarried cohabitating parents, and blended families comprised of stepparents, stepsiblings, and/or half-siblings. In addition, traditional gendered arrangements where the father is the breadwinner and the mother is a stay-at-home parent have diminished. Today, the vast majority of children are raised in families in which both parents are employed (U.S. Bureau of Labor Statistics, 2020b). The number of households with multigenerational families living under one roof has also increased (Cohn & Passel, 2018). These families may consist of children, parents, and grandparents living together as well as adult children, their children, and grandparents and great-grandparents living under one roof. The removal of legal barriers to marriage, adoption, and foster care for adults who are lesbian, gay, bisexual, transgender, or queer (LGBTQ) has led to an increase in queer-headed families (i.e., nonheterosexual and/or non-cisgender parents raising children; Goldberg & Allen, 2013; Haden & Applewhite, 2020). In addition, more young people are identifying as LGBTQ and at younger ages today than in past decades (Hall et al., 2020; Newport, 2018). There has also been growing social awareness of people with disabilities and mental impairments, perhaps due to the disability justice and neurodiversity movements. The disability community is a diverse one, with impairments spanning physical, sensory, developmental, learning, medical, and mental issues as well as strengths such as adaptability, perseverance, self-regulation, mutual support, and social collectivism. About 30% of families have at least one family member who has a disability (Wang, 2005). The present-day diverse contexts of families must be considered in

the development and implementation of social policies intended to promote child and adolescent well-being.

CONCEPTUAL FRAMEWORKS TO INFORM SOCIAL POLICY

Multiple conceptual lenses are necessary to think about the many complex issues involved in creating, implementing, and evaluating social policies for children, youth, and families. We present two conceptual frameworks to guide these efforts: (1) a person-in-environment and risk and resilience framework and (2) an intersectional anti-oppression framework. Throughout the book, these frameworks are reflected in the approaches to policies and programs intended to address various social and health problems.

A Person-in-Environment and Risk and Resilience Framework

An integrated person-in-environment and risk and resilience framework draws on concepts and tenants from a variety of disciplines, including public health, psychology, social work, and sociology. In social work, early pioneer Jane Addams wrote extensively on the impact of social, cultural, and policy environments on the well-being of individuals and families. She called for action and changes in these systems to improve the conditions of children, adults, and families living in poverty and facing distress (Austin, 2001; Germain & Hartman, 1980; Kondrat, 2013). Following the establishment of the National Association of Social Workers in 1955, Harriet Bartlett developed the first conceptualization of the person-in-environment perspective to inform social policy (Bartlett, 1958, 2003). Decades later, Urie Bronfenbrenner (1979) further explicated these concepts in his bioecological systems theory of development, and the ecological perspective has dominated the child development literature for the past several decades.

The person-in-environment and bioecological systems frameworks highly overlap (Bronfenbrenner, 2005; Bronfenbrenner & Morris, 2006; Kondrat, 2013). These frameworks rest on the idea that a young person's life is nested within levels of influence that are characterized by physical and social environments (e.g., home, neighborhood, school, community, parents' workplace, economic system, service systems, governments, built environment, and natural environment); these environments are purported to have both proximal and distal effects on children's lives. For example, a child's home and family context is a proximal system with direct and frequent contact with the child. Systems are also linked with each other, and distal systems can have direct and indirect influences on a child. To illustrate, income support, childcare, and employment policies may influence the ways in which parents interact with their children as well as children's caregiving contexts. This framework also posits that the relationships between children, youth, and families and

environmental systems are interactive and bidirectional. Just as the characteristics and resources available to a school influence the quality of the education a child may receive, so too can students and parents influence the school environment through student-led initiatives, cocurricular student groups, and parent–teacher associations or organizations.

Person-in-environment and bioecological systems perspectives evolved to emphasize the importance of history, time, and sociohistorical contexts in understanding child development. For example, historical events like the Great Recession of 2008 or the historical trauma inflicted upon Native Americans have profound effects on the current life experiences of children and families. The timing of life events and interactions also have implications for children. To illustrate, the loss of a job for a single parent may have a more deleterious effect on a child who is age 5 than age 17 because older adolescents are less dependent on their parents; they can seek part-time employment to supplement the family income and they may even have the skills necessary to help their parent find a job. Indeed, there are sensitive and critical periods in childhood and adolescence where events have greater or lesser impacts on overall development. For example, research shows that the first few years of life are critical for language acquisition (Friedmann & Rusou, 2015). And, as our prior discussion of American family diversity illustrates, the importance of the sociohistorical context must be taken into consideration. How can we help immigrant children and families without considering the current social, political, and policy climate they are facing? How can we improve the health care system for children and adolescents without understanding how the system currently functions and is funded? These are among the many vexing questions facing policymakers today.

Fraser and colleagues (Fraser, 2004; Fraser et al., 1999; Fraser et al., 2004; Fraser & Terzian, 2005; Jenson, 2004) integrated ideas and principles from *epidemiology*—the study of the distribution and determinants of diseases and health problems—with key elements of the person-in-environment framework (Kondrat, 2013). They focused on the interplay of factors at the individual and environmental levels that increase the likelihood of health and social problems among young people. Discussed in subsequent chapters, these problems include low birth weight, maltreatment, violence, victimization, school failure, poverty, housing instability, food insecurity, substance abuse, delinquency, sexually transmitted infections (STIs), depression, and anxiety. Fraser and colleagues also emphasized the importance of understanding the factors that protect children and youth and contribute to positive outcomes such as healthy birth weight, positive parent–child relationships, community safety, school success, housing stability, food security, prosocial behavior, and mental health. Key concepts of this integrated model include risk, protective, and promotive factors and the underlying principle of resilience.

Risk Factors

Risk factors are "any event, condition, or experience that increases the probability that a problem will be formed, maintained, or exacerbated" (Fraser & Terzian, 2005, p. 5).

This definition recognizes that the presence of one or more risk factors in a person's life can increase the likelihood that a health or social problem will occur at a later point in time. However, risk factors are not deterministic; the presence of a risk factor does not ensure or guarantee that a specific outcome (e.g., anxiety disorder and school dropout) will inevitably occur. Rather, the presence of a risk factor suggests an increased chance or probability that such a problem might develop.

Risk is temporal, contextual, and often modifiable. Temporally, risk factors precede the development of a deleterious outcome. Contextually, some risk factors depend on or are triggered by the environment. For example, research shows that there are genetic predispositions for many mental health disorders (Cross-Disorder Group of the Psychiatric Genomics Consortium, 2013; Sullivan et al., 2012). Therefore, children with certain genetic traits could be classified as being at higher risk for developing a mental health problem at some point in life. However, the expression of a genetic liability is often epigenetic in the sense that it may require or be based on enabling environmental conditions. In this sense, many risk factors—even genetic ones—are thought to be dependent on the context and, to the extent that the context can be purposively changed, they may be modifiable. The idea that risk factors are malleable through interventions is a key aspect of the risk and resilience perspective. Environmentally, for example, a child may attend a low-resource school where there are overcrowded classrooms, high levels of teacher burnout, few student service professionals (e.g., school counselors and social workers), and limited books and instructional technology—these conditions may increase students' risk for school dropout or not pursuing higher education. But these school risk factors can be modified . . . if we have the collective will to do so.

Because of the context dependence of risk, caution should be taken when ascribing risk to demographic groups. For example, youth who are LGBTQ are at increased risk for experiencing depression (Connolly et al., 2016; Marshal et al., 2011). However, research indicates that it is not these youth's sexual orientation or gender identity itself that causes the risk but rather the negative ways social contexts interact with these youth that increases their risk for depression (Hall, 2018; Hoffman, 2014). From an intervention standpoint, we are interested in both markers of risk and malleable risk factors because children and youth who are more vulnerable to certain problems may need particular interventions to minimize their likelihood for developing a problem. Identifying and targeting modifiable risk conditions is a basis for designing social interventions and public policies.

Although the presence of a single risk factor has the capacity to disrupt healthy development if it is severe or enduring, the presence of cumulative risk is also highly concerning. Risk factors can manifest as bundles, piles, or clusters (e.g., Lanier et al., 2018). For example, a pregnant person may be at increased risk for having a low birth weight baby due to multiple factors present during pregnancy. An expecting parent may live in an impoverished area that is a food desert with limited access to affordable, healthful food. In addition to the expecting parent's risk for poor nutrition, transportation barriers may prevent them from attending recommended prenatal care visits. Risk factors can also function as chains or cascades of risk in which one risk factor leads

to others, building over time. For example, a child's parent unexpectedly dies. The remaining parent is stricken with grief and adjusting to the additional stress of being a single parent; consequently, the parent has difficulty helping the child with their grief. The family may move to another part of the country to be closer to extended family; however, the child loses connections with friends, family friends, and caring adults in professional roles. The child develops separation anxiety with depressed mood, which interferes with school and other activities. In this sense, one risk factor chains to another risk factor. Risk accumulates.

From a person-in-environment perspective, risk factors typically occur at individual, family, school, peer, and community levels of influence. It is important to note that common problems in childhood and adolescence, such as aggression, school failure, and substance use, share many of the same risk factors (Jenson & Bender, 2014). This "shared" sense of risk means that effective social policies and programs have the potential to simultaneously affect a number of behaviors and outcomes. Table 1.1 presents common risk factors for childhood and adolescent problems by level of influence. These and other risk factors are discussed in relation to specific problem areas and corresponding policies in ensuing chapters.

Protective and Promotive Factors

Protective factors are characteristics, conditions, and resources that buffer or mitigate the impact of risk, interrupt risk processes, or prevent adverse outcomes altogether (Fraser et al., 1999; Fraser et al., 2004; Fraser & Terzian, 2005). Protective factors can be individual attributes (e.g., emotional self-regulation skills) or environmental characteristics (e.g., positive school climate) that function in three main ways. First, protective factors can cushion against the negative effects of risk factors (e.g., social support from family can buffer the effect of being in a hostile school climate for a student). Second, protective factors can interrupt a risk chain (e.g., coaching for parents whose children exhibit disruptive behavior can promote responsive parenting and prevent child behavior problems from escalating into oppositional defiant disorder, school problems, and child maltreatment). Third, protective factors can prevent the onset of problems (e.g., a baby with a temperament that adapts easily to new situations, accepts regular sleeping and feeding patterns, and usually exhibits a pleasant mood could protect the child from maltreatment ever occurring even if the parent is facing many challenges constraining their capacity for parenting). Table 1.2 shows common protective factors.

Promotive factors for child and adolescent behaviors can be distinguished from protective factors in several ways. As noted above, protective factors serve to reduce or buffer exposure to risk; these are factors in young people's lives that serve to increase positive behavior by offsetting the effects of high levels of risk. In contrast, *promotive factors* represent individual and environmental characteristics that are associated with positive outcomes regardless of underlying levels of risk (Sameroff, 2000). Promotive factors, therefore, promote positive outcomes for all children regardless of risk level whereas protective factors reduce or buffer children who are already at higher risk for adverse outcomes. *Self-efficacy*, the belief that you can successfully perform a set

Table 1.1 Risk Factors for Childhood and Adolescent Problems by Level of Influence

Individual Factors
Genetic predisposition
Prenatal or postnatal complications
Chronic illness
Difficult temperament
Poor attachment with parents
Limited capacity for self-regulation
Sedentary behavior and excessive screen time
Low self-worth
Lack of social skills and problem-solving skills
Favorable attitudes toward problematic behaviors
Family and Household Factors
Family economic hardship
Housing instability
Food insecurity
Parental struggles with mental illness, substance abuse, or criminal activity
Conflict or violence between parents
Harsh or inconsistent parenting practices
Lack of parental warmth and involvement
Child abuse and neglect
Favorable attitudes of parents toward problematic behaviors
School and Peer Factors
Unsupportive school climate
Low commitment to or engagement in school
Low academic performance
Bullying or rejection by peers
Affiliation with peers who engage in delinquent behavior
Loss of social support

(Continued)

Table 1.1 (Continued)

Community and Societal Factors
High community poverty levels
Presence of toxins, hazards, and health threats
Disadvantaged and disorganized neighborhood
Blocked opportunities for socioeconomic advancement
Discrimination and systemic injustice
Media portrayals of violence and problematic behaviors
Policies and norms favorable to problematic behaviors

Sources: Adapted from Fraser et al. (2004); Jenson and Bender (2014); O'Connell et al. (2009); and Rickwood and Thomas (2019).

Table 1.2 Protective Factors for Childhood and Adolescent Problems by Level of Influence

Individual Factors
Easy temperament
High intelligence
Self-regulation skills, social skills, and problem-solving skills
Positive attitude
Engagement in physical activity
Positive self-concept
Low childhood stress
Family and Household Factors
Adequate socioeconomic resources
Authoritative parenting
Supportive and caring relationships among family members
Attachment to parents or caregivers and positive parent–child relationship
Clear expectations for prosocial behavior and values
Support from extended family
Low parental conflict

School and Peer Factors
Support for early learning
Connectedness and engagement with school
Positive teacher expectations
Positive student–teacher relationships
Effective classroom management
School practices and policies against bullying
Positive school–family partnership
Ability to make friends and get along with others
Positive relationships with peers
Community and Societal Factors
Opportunities for education, employment, and other prosocial activities (e.g., athletics, religion/spirituality, culture)
Cohesive and supportive neighborhood
Supportive relationships with mentors, helping professionals, and other caring adults
Positive social norms about behavior
Access to green space and recreational space
Physical and psychological safety

Sources: Adapted from Fraser et al. (2004); Jenson and Bender (2014); O'Connell et al. (2009); and Rickwood and Thomas (2019).

of tasks and attain a goal (or control outcomes in a certain context), is an example of a promotive factor because it is thought to be beneficial for all children and youth in achieving overall healthy development.

Resilience

Resilience is characterized by successful adaptation in the presence of risk or adversity (Garmezy, 1986; Luthar, 2003; Rutter, 2012; Ungar, 2011; Werner, 1989). This common definition implies that resilience is the outcome of a process involving both risk and protective factors. Unfortunately, when exposure to adversity is very high and protection is low, children and adolescents experience some type of problem or developmental difficulty (e.g., Cicchetti & Rogosch, 1997; Pollard et al., 1999). Yet, most children recover from risk exposure (Boyce, 2017). In vivo, individuals facing a threat often find support and resources in protective factors found in their environments

to achieve a more positive outcome than would be expected. Children who experience adverse events such as maltreatment, poverty, and parent mental illness may not develop behavioral health problems because they have supportive friends, family members, and teachers. In addition, some children and youth who experience adversity may not merely cope well, showing adequate adaptation, but may develop new skills, insights, and resources through their resilience or recovery process that enable them to flourish as they move forward in life (Vloet et al., 2017); these outcomes point to the power of resilience in young people's lives. Indeed, there are many expressions and terms to characterize processes leading to resilience (e.g., *overcoming the odds*, *rebounding*, *bouncing back*, *grit*, *steeling*, *sustained competence under stress*, *recovery*, and *post-traumatic growth*).

Figure 1.1 displays the person-in-environment and risk and resilience framework. As seen in this figure, stressors, traumas, and adverse experiences across levels can press down on children, increasing the likelihood of deleterious outcomes. Equally important, protective and promotive factors buffer exposure to risk and support children and families by promoting resilience and general well-being.

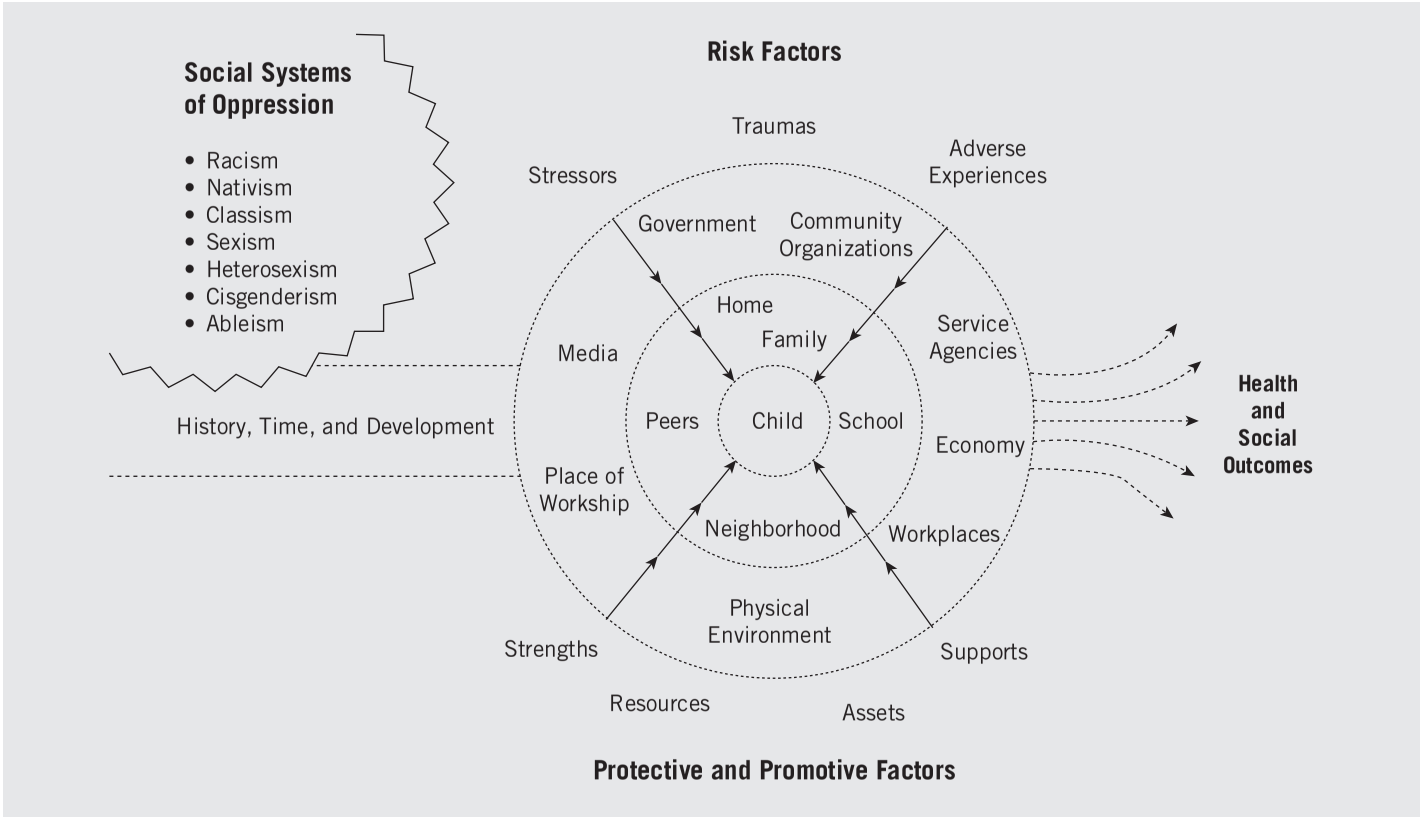
We turn next to a discussion of the intersectional anti-oppression framework, our second conceptual model for guiding the development and implementation of social policies for children and families.

Intersectional Anti-Oppression Framework

Systems of oppression are embedded in society in many forms, including racism, nativism, classism, sexism, heterosexism, cisgenderism, and ableism (Garcia & Van Soest, 2019; National Museum of African American History & Culture, 2020; Young, 2018). These systems confer advantages to dominant groups such as White people, native-born citizens, high-income families, men, heterosexuals, cisgender people, and people without disabilities or impairments. At the same time, systems of oppression often disadvantage people of color, immigrants, low-income families, women, queer people, transgender people, and people with disabilities through processes of discrimination, violence, marginalization, exploitation, and disempowerment. Many of the risk factors and processes affecting young people are driven by systems of oppression that pervade U.S. social contexts (e.g., McCrea et al., 2019).

Systems of oppression differentially affect children and youth, depending on an individual's set of identities and social statuses (e.g., racial/ethnic identity and socioeconomic status). The term *intersectionality* was coined by Kimberlé Crenshaw in 1989 to draw attention to the ways in which systems of oppression tend to intersect and influence particular individuals and groups. Forms of intersectionality are often derived from, or lead to, unique experiences of privilege or marginalization that cannot be understood by examining systems of oppression individually or in parallel. For example, a young Black man may face police discrimination that is not entirely due to his race (because force used by police during a stop is often greater for Black men than Black women) and not entirely due to his gender (because force used by police during a stop is often greater for Black men than White men). The discrimination displayed

Figure 1.1 A Person-in-Environment and Risk and Resilience Framework



by the officer is due to the combination of the Black man's race and gender, an intersection involving oppression.

Many academic disciplines and helping professions, including education, family studies, human development, psychology, public health, public policy, social work, and sociology, acknowledge the importance of understanding diversity and challenging social systems of oppression in their research or practice (American Association for Public Policy Analysis & Management, n. d.; American Association of Family & Consumer Sciences, 2013; American Psychological Association, 2017; American Public Health Association, n. d.; American Society for Public Administration, 2014; American Sociological Association, 2018; National Association of Social Workers, 2017; National Council on Family Relations, 1998, 2018; National Education Association, 2020; Society for Prevention Research, 2020; Society for Social Work and Research, 2020). Through an intersectional anti-oppression lens, helping professionals can understand the unique and multilayered challenges individuals, families, and communities face, which can inform interventions used; in addition, these professionals can advocate for structural and institutional changes to create a more just and equitable society.

An intersectional anti-oppression perspective provides an important context for social policy. This framework acknowledges the unique forms of diversity of individuals and groups in their identities and social statuses. Systems of oppression operate invidiously throughout social contexts and environments, impacting children, youth, and families in different ways. The interconnections of oppressive systems must be accounted for to fully understand the unique experiences of marginalization of individuals and groups. An intersectional anti-oppressive framework can also inform interventions to address the needs of specific groups and inform policies to address problems affecting multiple marginalized populations through linked systems of oppression. An example of the former would be a community-based psychological intervention with Latinx sexual minority men who are HIV positive to improve coping and adherence to antiretroviral treatment (Bogart et al., 2020). An example of the latter would be environmental and waste management policy to address the location of landfills and environmental toxins disproportionately near neighborhoods with high proportions of Black Americans, Mexican immigrants, and low-income families (Bakhtsiyarava & Nawrotzki, 2017; Hunter, 2000; Martuzzi et al., 2010; Mohai et al., 2009; Mohai & Saha, 2007).

The upper left corner of Figure 1.1 of the person-in-environment and risk and resilience framework displays prominent systems of oppression relevant to health and social issues facing children, youth, and families. Although these systems are historically rooted, they continue to be prevalent in U.S. society and in other societies as well. Further, oppression can operate in many ways: intrapersonally (e.g., prejudice and internalized oppression), interpersonally (e.g., harassment and microaggressions), institutionally (e.g., discriminatory laws and organizational practices), and culturally (e.g., ideals and norms benefiting dominant groups). These systems affect children and families differently depending on specific intersections of race/ethnicity, immigrant or citizenship status, socioeconomic standing, sex, sexual orientation, gender identity, and ability or disability status.

A PUBLIC HEALTH SOCIAL WORK INTERVENTION APPROACH

Elements of the person-in-environment and risk and resilience framework and of the intersectional anti-oppression framework provide important principles for developing, implementing, and evaluating interventions aimed at promoting healthy development in young people. These principles—especially reducing risk and promoting resilience—can be maximized in the context of a public health social work intervention approach. In broad terms, *public health* is focused on protecting and improving the health of the entire population. Public health interventions are typically broad in nature and seek to thwart adverse health outcomes among entire communities and population groups. They tend to focus on prevention and health promotion. They include, for example, providing vaccinations for infectious diseases, offering health education to prevent STIs, increasing opportunities for physical activity, conducting communication campaigns about handwashing, and improving access to health care systems. Although *health* is defined holistically as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity" (World Health Organization [WHO], 1948), public health interventions have historically emphasized physical health over mental and social well-being.

A sister profession to public health is social work. *Social work* is focused on helping people meet their basic needs, providing mental health and social services, community organizing, and advocating for social change. Although many social workers work in administration and organizational leadership, policy analysis and advocacy, and community- and systems-level change, the majority of social workers provide direct services to individuals, families, and groups to resolve or prevent psychosocial problems, increase access to social and economic resources, and sustain or enhance strengths and empowerment. By drawing upon both public health and social work approaches, we can comprehensively address the array of often-interconnected health and social problems affecting children, youth, and families.

Understanding social policy is essential not only for policymakers but also for helping professionals whose work is shaped by policy and the systems in which they operate. *Social policies* are sets of standards and rules created by governing bodies or public officials to achieve specific outcomes regarding human welfare by guiding action and decision making. Policies exist in many domains, including housing, labor, child welfare, income assistance, education, health, immigration, law enforcement, and criminal justice. Policies often aim to address particular social problems such as child maltreatment, drug abuse, poverty, and violence. Typically, policies are not intended to remain high-level statements forged by authority figures; rather, they are intended to influence the choices and actions of members of society and professionals at the ground level. McKinlay (1998) described policies as upstream interventions that influence downstream interventions. As shown in Figure 1.2, this stream represents a continuum of interventions with population-level policies on one end and individual-level interventions at another end.

Social policies are crafted to guide and regulate intervention programs, practices, and services. For young people and their families, for example, an anti-bullying policy may be adopted at the state level and implemented at the school level (Hall, 2017). Such a policy may require training all school employees to implement a bullying prevention program, integrating bullying awareness and education into classroom lessons, and providing counseling for students involved in bullying. In this case, by outlining goals and directives, policy lays the groundwork for an array of more specific interventions to be deployed at the local level.

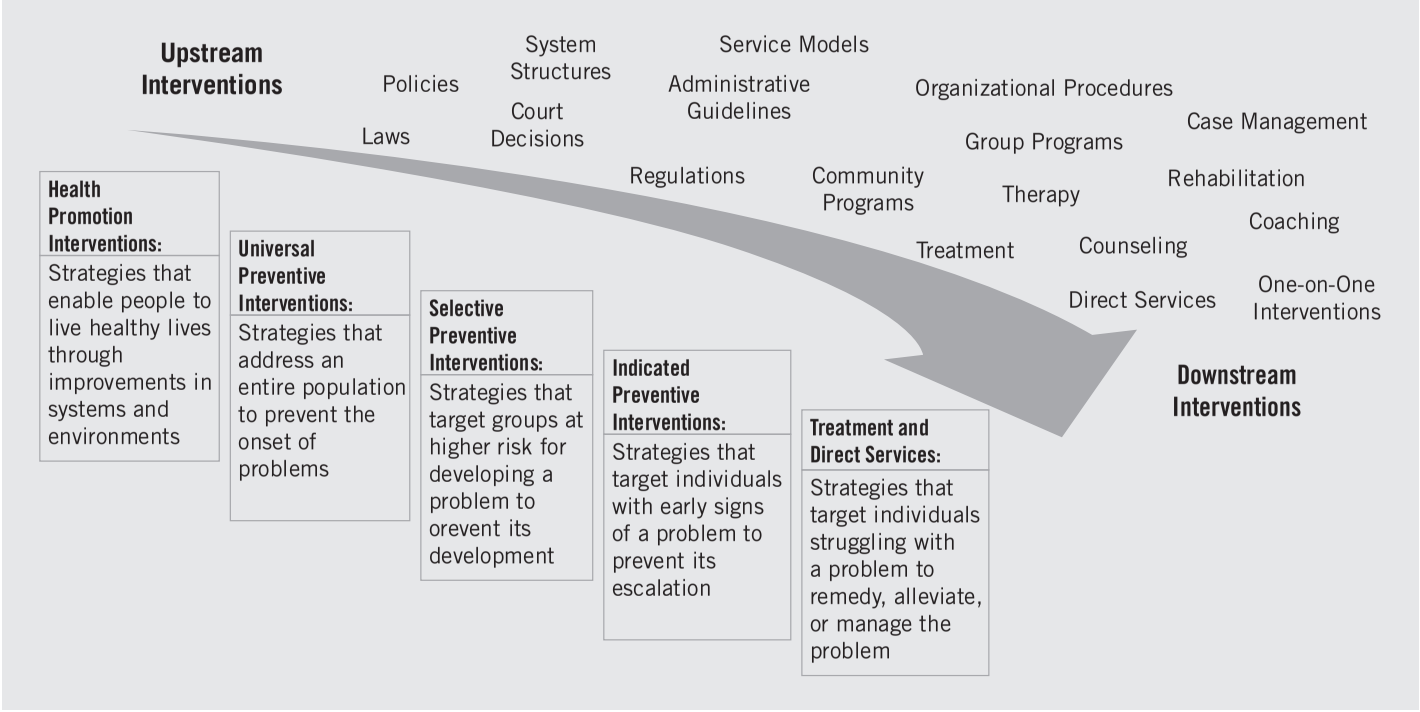
A continuum of interventions, as illustrated in Figure 1.2, can be conceptualized as promoting positive child development, preventing behavior problems that are likely to arise, mitigating the impact of adversity, and remediating problems that have already become manifest (Hawkins et al., 2015; Jenson, 2018, 2020; Jenson & Bender, 2014; Jenson & Hawkins, 2018; Mrazek & Haggerty, 1994; Munoz et al., 1996; National Academies of Sciences, Engineering, and Medicine, 2019a, 2019b; O'Connell et al., 2009). That is, a public health social work approach can provide for health promotion, universal prevention, selective prevention, indicated prevention, and treatment and direct services. The application of principles outlined in the person-in-environment and risk and resilience framework and in the intersectional anti-oppression framework are key to these efforts.

Applying a Public Health Social Work Intervention Approach

Communities That Care (CTC) is an illustrative example of a public health social work intervention approach. CTC aims to prevent youth problem behaviors such as violence, delinquency, school dropout, and substance abuse (The Center for CTC, 2020). CTC is based on the social development model that centers on a protective mechanism involving several key elements: (1) opportunities for prosocial socialization and behavior for children and youth; (2) child and youth involvement in family, school, community, and peer environments that share values, beliefs, and norms for prosocial behavior; (3) bonding to individuals in these environments in terms of attachment and commitment; (4) rewards for interaction with prosocial groups and communities; and (5) social, cognitive, and emotional skills that enable children and youth to solve problems, to socially interact with others and successfully navigate social situations, and to resist influences and impulses that would violate their norms for behavior (Cambron et al., 2019; Catalano & Hawkins, 1996; Hawkins & Weis, 1985).

CTC is currently being implemented in a variety of cities, towns, neighborhoods, and school catchment areas (The Center for CTC, 2020). Leaders in the CTC communities form a coalition and conduct surveys with youth, parents, and community members to identify risk factors, protective factors, and problem behaviors that are most salient in their local area. Survey results, combined with local administrative data (e.g., school dropout rates), are used to determine which factors and behaviors to target in prevention and intervention efforts; these data also serve as baseline data to evaluate the effectiveness of CTC on targeted outcomes over time. Coalition members then

Figure 1.2 A Public Health Social Work Intervention Approach



select evidence-based intervention programs and policies that target the identified risk and protective factors and implement them in their community. Interventions may include a school-based anti-bullying program involving training staff to intervene in bullying, developing schoolwide anti-bullying policies, teaching empathy and respect to students through classroom lessons, and maintaining adult supervision throughout school settings; a driving license restriction policy to prevent further alcohol-related driving offenses; and a parent training program on family management skills to prevent problem behaviors among children. CTC has been rigorously tested and has been found to be effective in preventing and reducing a number of behavioral health problems in young people (Chilenski et al., 2019; Hawkins et al., 2009; Hawkins et al., 2014; Oesterle et al., 2018). Results from longitudinal research and randomized trials shows significantly lower rates of delinquency; violent behavior; alcohol, cigarette, and marijuana use; severe substance use; suspension from school; and depressive symptoms among youth in CTC intervention communities as compared with control communities. These groundbreaking findings suggest that well-organized and well-implemented community interventions that focus on risk and protection can lead to positive outcomes for young people.

CRITICAL SOCIAL POLICY ISSUES TO CONSIDER

There are several critical social policy issues to consider as you read the subsequent chapters of this book and move forward in your career as a helping professional, public servant, or social researcher. These issues include

- the extent that policies designed to address the well-being of children, youth, and families are informed by evidence about risk, protection, and resilience;
- the extent that policies recommend, require, or encourage evidence-based interventions;
- the extent that issues of diversity and inequity are addressed in the policies, programs, practices, and services designed to assist America's diverse families and marginalized young people;
- the extent that policies, programs, practices, and services focus sufficiently on prevention and health promotion; and
- opportunities to better integrate services for children, youth, and families across social institutions or system domains.

Using a person-in-environment and risk and resilience framework as well as an intersectional anti-oppression framework in the design of social policy is an emerging challenge. These frameworks provide a means for infusing policy with research knowledge.

Unfortunately, failures litter the policy landscape. For example, school-based sex education policies have historically emphasized abstinence-only sex education (Hall et al., 2019; Sexuality Information and Education Council of the United States, 2019), despite substantial evidence that this approach is ineffective at preventing unwanted adolescent pregnancy and the spread of STIs (Chin et al., 2012; Fox et al., 2019; Kohler et al., 2008; Petrova & Garcia-Retamero, 2015; Underhill et al., 2007). Furthermore, despite the availability of numerous evidence-based comprehensive sex education programs (Goesling et al., 2014; Manlove et al., 2015), federal and state policies continue to recommend and fund abstinence-only programs in schools (Hall et al., 2019; Kaiser Family Foundation, 2018).

Policy often falls short in addressing the inequities and marginalization produced by systems of oppression. For example, bullying in schools continues to be a pervasive and persistent threat to the well-being of youth (Basile et al., 2020), disproportionately affecting youth who are members of minority groups (e.g., LGBTQ youth, immigrant youth, and youth with disabilities; Hall & Chapman, 2018). However, most state anti-bullying policies do not provide specific protections for these vulnerable youth. They fail, on balance, to prohibit bullying based on race, national origin, socioeconomic status, sex, sexual orientation, gender identity, and ability/disability status, despite evidence indicating that such protections may reduce bias-based bullying (Cosgrove & Nickerson, 2017; Hall, 2017; Hall & Dawes, 2019).

As indicated in Figure 1.2 and as suggested by the findings from the CTC studies, greater emphasis must be placed on health promotion and preventive interventions in social policies for children and families. Health promotion resources and activities can be integrated into everyday social settings, especially schools (WHO, 2020). Prevention is particularly relevant to social policies for children and families, as childhood and adolescence represent developmental stages in which young people form patterns of behavior (Jenson, 2020). These patterns, learned in family, school, and other contexts, have important implications far into adulthood (Hall & Rounds, 2013). Rather than health promotion and prevention (e.g., prevention of violence, delinquency, substance abuse, and school dropout), public policies have historically focused on punishment, control, treatment, and rehabilitation (Hawkins et al., 2015; Jenson & Bender, 2014; Jenson et al., 2001). This focus costs the U.S. society hundreds of billions of dollars annually (Miller, 2004; O'Connell et al., 2009). For example, youth perpetration of violence and criminal activity is associated with health care costs for injured victims; property loss or damage; police, legal/court, correctional facility, and probation costs; employment losses; and decreased quality of life for victims and families. The costs of preventing such problems are often a fraction of the cost to address the aftereffects once behavior problems have occurred (Aos et al., 2004; Kuklinski, 2015; WHO, 2014). Prevention research has boomed in recent decades, resulting in dozens of efficacious preventive interventions that are widely available to address mental health problems, school failure, delinquency, substance abuse, risky health behaviors, and violence (Hawkins et al., 2015; Jenson & Bender, 2014; Jenson & Hawkins, 2018).

Finally, public service systems are often fragmented, attempting to address the many needs of children and adolescents in uncoordinated and inefficient ways. Such arrangements are especially deleterious to young people with multiple, high-level needs,

such as children and youth with special health care needs. These young people face chronic physical and/or psychological conditions requiring health and other services above what is required for most children and youth (McPherson et al., 1998). These children and their families often depend on an array of services and resources spanning basic needs to specialized medical care that are scattered amongst social service agencies, schools, community-based organizations, and health care systems (Mattson et al., 2019). Indeed, many gaps remain to providing integrated care and services to our most vulnerable children and youth (e.g., An, 2016; Rosen-Reynoso et al., 2016).

SUMMARY

Knowledge gained from the study of risk, protection, and resilience has improved our understanding of the onset and persistence of many social and health problems. At the same time, the person-in-environment and risk and resilience perspective helps us understand the contextual boundedness of social and health problems. Through the application of an intersectional anti-oppression framework, we may better understand how ideologies and institutionalized practices (often deeply embedded in society) condition opportunity, confer privilege, and promote marginalization. To date, these perspectives and the new knowledge they represent have not been systematically incorporated in the design and implementation of social policies for children and families.

In this chapter, we have outlined a public health social work approach to social policy and intervention. This approach is grounded in frameworks that have emerged from recent research and models that offer enduring perspectives in child development. The incorporation of these frameworks in social policies for children and families is the challenge that we confront as professionals who seek a more just, humane, and enriching society. In subsequent chapters, authors more fully examine this emerging point of view by applying it to a host of policy and practice domains.

REFERENCES

American Association for Public Policy Analysis & Management. (n. d.). *Code of conduct*. https://www.appam.org/assets/1/7/APPAM_Code_of_Conduct2.pdf

American Association of Family & Consumer Sciences. (2013). *AAFCS code of ethics*. https://higherlogicdownload.s3.amazonaws.com/AAFCS/1c95de14-d78f-40b8-a6ef-a1fb628c68fe/UploadedImages/About/AAFCS_Code_of_Ethics_2013.pdf

American Lung Association. (2020). *State of the air*. Author.

An, R. (2016). Unmet mental health care needs in U.S. children with medical complexity, 2005–2010. *Journal of Psychosomatic Research*, *82*, 1–3.

American Psychological Association. (2017). *Ethical principles of psychologists and code of conduct*. https://www.apa.org/ethics/code

American Public Health Association. (n. d.). *Public health code of ethics*. https://www.apha.org/-/media/files/pdf/membergroups/ethics/code_of_ethics.ashx

American Society for Public Administration. (2014). *Code of ethics*. https://www.aspanet.org/ASPA/Code-of-Ethics/Code-of-Ethics.aspx

American Sociological Association. (2018). *Code of ethics*. https://www.asanet.org/sites/default/files/asa_code_of_ethics-june2018a.pdf

An, R. (2016). Unmet mental health care needs in US children with medical complexity, 2005–2010. *Journal of Psychosomatic Research*, *82*, 1–3.

Aos, S., Lieb, R., Mayfield, J., Miller, M., & Pennucci, A. (2004). *Benefits and costs of prevention and early intervention programs for youth*. Washington State Institute for Public Policy.

Austin, D. (2001). Guest editor's foreword. *Research on Social Work Practice*, *11*(2), 147–151.

Bakhtsiyarava, M., & Nawrotzki, R. J. (2017). Environmental inequality and pollution advantage among immigrants in the United States. *Applied Geography*, *81*, 60–69.

Bartlett, H. M. (1958). Toward clarification and improvement of social work practice. *Social Work*, 3–9.

Bartlett, H. M. (2003). Working definition of social work practice. *Research on Social Work Practice*, *13*(3), 267–270.

Basile, K. C., Clayton, H. B., DeGue, S., Gilford, J. W., Vagi, K. J., Suarez, N. A., Zwald, M. L., & Lowry, R. (2020). Interpersonal violence victimization among high school students—Youth Risk Behavior Survey, United States, 2019. *Morbidity and Mortality Weekly Report*, *69*(1), 28–37.

Bogart, L. M., Barreras, J. L., Gonzalez, A., Klein, D. J., Marsh, T., Agniel, D., & Pantalone, D. W. (2020). Pilot randomized controlled trial of an intervention to improve coping with intersectional stigma and medication adherence among HIV-positive Latinx sexual minority men. *AIDS and Behavior*.

Boyce, W. T. (2017). Epigenomic susceptibility to the social world: Plausible paths to a "newest morbidity." *Academic Pediatrics*, *17*(6), 600–606.

Bronfenbrenner, U. (1979). *The ecology of human development: Experiments by nature and design*. Harvard University Press.

Bronfenbrenner, U. (2005). *Making human beings human: Bioecological perspectives on human development*. SAGE.

Bronfenbrenner, U., & Morris, P. A. (2006). The bioecological model of human development. In R. M. Lerner (Ed.), *Handbook of child psychology—Volume 1: Theoretical models of human development* (6th ed., pp. 793–828). Wiley.

Budiman, A. (2020). *Key findings about U.S. immigrants*. Pew Research Center.

Cambron, C., Catalano, R. F., & Hawkins, J. D. (2019). The social development model. In D. P. Farrington, L. Kazemian, & A. R. Piquero (Eds.), *Oxford handbook of developmental and life course criminology* (pp. 224–247). Oxford University Press.

Catalano, R. F., & Hawkins, J. D. (1996). The social development model: A theory of antisocial behavior. In J. D. Hawkins (Ed.), *Delinquency and crime: Current theories* (pp. 149–197). Cambridge University Press.

The Center for Communities That Care (CTC). (2020). *Communities that care*. University of Washington. https://www.communitiesthatcare.net/

Centers for Disease Control and Prevention (CDC). (2019). *Leading causes of death*. https://www.cdc.gov/healthequity/lcod/index.htm

Centers for Disease Control and Prevention (CDC). (2020). *COVID-19 death data and resources*. https://www.cdc.gov/nchs/nvss/vsrr/covid_weekly/index.htm

Children's Defense Fund. (2020). *The state of America's children 2020*. Author.

Chilenski, S. M., Frank, J., Summers, N., & Lew, D. (2019). Public health benefits 16 years after a statewide policy change: Communities That Care in Pennsylvania. *Prevention Science*, *20*(6), 947–958.

Chin, H. B., Sipe, T. A., Elder, R., Mercer, S. L., Chattopadhyay, S. K., Jacob, V., Wethington, H. R., Kirby, D., Elliston, D. B., Griffith, M., Chuke, S. O., Briss, S. C., Ericksen, I., Galbraith, J. S., Herbst, J. H., Johnson, R. L., Kraft, J. M., Noar, S. M., Romero, L. M., & Santelli, J. (2012). The effectiveness of group-based comprehensive risk-reduction and abstinence education interventions to prevent or reduce the risk of adolescent pregnancy, human immunodeficiency virus, and sexually transmitted infections: Two systematic reviews for the guide to community preventive services. *American Journal of Preventive Medicine*, *42*(3), 272–294.

Cicchetti, D., & Rogosch, F. A. (1997). The role of self-organization in the promotion of resilience in maltreated children. *Development and Psychopathology*, *9*, 787–815.

Cohn, D., & Passel, J. (2018). *A record 64 million Americans live in multigenerational households*. Pew Research Center.

Connolly, M. D., Zervos, M. J., Barone, C. J., II, Johnson, C. C., & Joseph, C. L. (2016). The mental health of transgender youth: Advances in understanding. *Journal of Adolescent Health*, *59*(5), 489–495.

Cosgrove, H. E., & Nickerson, A. B. (2017). Anti-bullying/harassment legislation and educator perceptions of severity,

effectiveness, and school climate: A cross-sectional analysis. *Educational Policy*, *31*(4), 518–545.

Crenshaw, K. (1989). Demarginalizing the intersection of race and sex: A Black feminist critique of antidiscrimination doctrine, feminist theory, and antiracist politics. *University of Chicago Legal Forum*, *1*(8).

Cross-Disorder Group of the Psychiatric Genomics Consortium. (2013). Genetic relationship between five psychiatric disorders estimated from genome-wide SNPs. *Nature Genetics*, *45*(9), 984.

Family Health in Europe–Research in Nursing Group. (2020). The COVID-19 pandemic: A family affair. *Journal of Family Nursing*, *26*(2), 87–89.

Fegert, J. M., Vitiello, B., Plener, P. L., & Clemens, V. (2020). Challenges and burden of the Coronavirus 2019 (COVID-19) pandemic for child and adolescent mental health: A narrative review to highlight clinical and research needs in the acute phase and the long return to normality. *Child and Adolescent Psychiatry and Mental Health*, *14*, 1–11.

Fox, A. M., Himmelstein, G., Khalid, H., & Howell, E. A. (2019). Funding for abstinence-only education and adolescent pregnancy prevention: Does state ideology affect outcomes? *American Journal of Public Health*, *109*(3), 497–504.

Fraenkel, P., & Cho, W. L. (2020). Reaching up, down, in, and around: Couple and family coping during the coronavirus pandemic. *Family Process*.

Fraser, M. W. (2004). The ecology of childhood: A multisystems perspective. In M. W. Fraser (Ed.), *Risk and resilience in childhood* (2nd ed., pp. 1–12). NASW Press.

Fraser, M. W., Kirby, L. D., & Smokowski, P. R. (2004). Risk and resilience in childhood. In M. W. Fraser (Ed.), *Risk and resilience in childhood: An ecological perspective* (2nd ed., pp. 13–66). NASW Press.

Fraser, M. W., Richman, J. M., & Galinsky, M. J. (1999). Risk, protection, and resilience: Towards a conceptual framework for social work practice. *Social Work Research*, *23*, 131–144.

Fraser, M. W., & Terzian, M. A. (2005). Risk and resilience in child development: Practice principles and strategies. In G. P. Mallon & P. McCartt Hess (Eds.), *Handbook of children, youth, and family services: Practice, policies, and programs* (pp. 55–71). Columbia University Press.

Friedmann, N., & Rusou, D. (2015). Critical period for first language: the crucial role of language input during the first year of life. *Current Opinion in Neurobiology*, *35*, 27–34.

Garcia, B., & Van Soest, D. (2019). Oppression. In C. Franklin (Ed.), *Encyclopedia of social work*. National Association of Social Workers Press and Oxford University Press.

Garmezy, N. (1986). On measures, methods, and models. *Journal of the American Academy of Child and Adolescent Psychiatry*, *25*, 727–729.

Germain, C. B., & Hartman, A. (1980). People and ideas in the history of social work. *Social Casework*, *61*(1), 323–331.

Goesling, B., Colman, S., Trenholm, C., Terzian, M., & Moore, K. (2014). Programs to reduce teen pregnancy, sexually transmitted infections, and associated sexual risk behaviors: A systematic review. *Journal of Adolescent Health*, *54*(5), 499–507.

Goldberg, A. E., & Allen, K. R. (2013). *LGBT-parent families*. Springer.

Grimm, R. T., Jr., & Dietz, N. (2018). *Good intentions, gap in action: The challenge of translating youth's high interest in doing good into civic engagement*. Do Good Institute, University of Maryland.

Haden, S. C., & Applewhite, K. (2020). Parents who are lesbian, gay, bisexual, or transgender. In S. Hupp & J. D. Jewell (Eds.), *The encyclopedia of child and adolescent development*. John Wiley & Sons.

Hall, W. J. (2017). The effectiveness of policy interventions for school bullying: A systematic review. *Journal of the Society for Social Work and Research*, *8*(1), 45–69.

Hall, W. J. (2018). Psychosocial risk and protective factors for depression among lesbian, gay, bisexual, and queer youth: A systematic review. *Journal of Homosexuality*, *65*(3), 263–316.

Hall, W. J., & Chapman, M. V. (2018). Fidelity of implementation of a state anti-bullying policy with a focus on protected social classes. *Journal of School Violence*, *17*, 58–73.

Hall, W. J., & Dawes, H. C. (2019). Is fidelity of implementation of an anti-bullying policy related to student bullying and teacher protection of students? *Education Sciences*, *9*, 112.

Hall, W. J., Dawes, H. C., & Plocek, N. (2020). *Sexual orientation identity development milestones among lesbian,*

gay, bisexual, and queer people: A systematic review and meta-analysis. [Manuscript submitted for publication]

Hall, W. J., Jones, B. L. H., Witkemper, K. D., Collins, T., & Rodgers, G. K. (2019). State policy on school-based sex education: A content analysis focused on sexual behaviors, relationships, and identities. *American Journal of Health Behavior*, *43*, 506–519.

Hall, W. J., & Rounds, K. A. (2013). Adolescent health. In the Public Health Social Work Section of the American Public Health Association, R. H. Keefe, & E. T. Jurkowski (Eds.), *Handbook for public health social work* (pp. 59–80). Springer.

Hawkins, J. D., Jenson, J. M., Catalano, R., Fraser, M. W., Botvin, G. J., Shapiro, V., Hendricks Brown, C., Beardslee, W., Brent, D., Leslie, L. K., Rotheram-Borus, M. J., Shea, P., Shih, A., Anthony, E., Haggerty, K. P., Bender, K., Gorman-Smith, D., Casey, E., & Stone, S. (2015). *Unleashing the power of prevention*. National Academy of Medicine.

Hawkins, J. D., Oesterle, S., Brown, E. C., Abbott, R. D., & Catalano, R. F. (2014). Youth problem behaviors 8 years after implementing the Communities That Care prevention system: A community-randomized trial. *JAMA Pediatrics*, *168*(2), 122–129.

Hawkins, J. D., Oesterle, S., Brown, E. C., Arthur, M. W., Abbott, R. D., Fagan, A. A., & Catalano, R. F. (2009). Results of a type 2 translational research trial to prevent adolescent drug use and delinquency: A test of Communities That Care. *Archives of Pediatrics and Adolescent Medicine*, *163*(9), 789–798.

Hawkins, J. D., & Weis, J. G. (1985). The social development model: An integrated approach to delinquency prevention. *Journal of Primary Prevention*, *6*(2), 73–97.

Hoffman, B. (2014). An overview of depression among transgender women. *Depression Research and Treatment*.

Hunter, L. M. (2000). The spatial association between US immigrant residential concentration and environmental hazards. *International Migration Review*, *34*(2), 460–488.

Hussar, B., Zhang, J., Hein, S., Wang, K., Roberts, A., Cui, J., Smith, M., Bullock Mann, F., Barmer, A., & Dilig, R. (2020). *The condition of education 2020. National Center for Education Statistics*. U.S. Department of Education.

International Energy Agency. (2020). *CO_2 emissions from fuel combustion*. http://energyatlas.iea.org/#!/tellmap/1378539487

Jenson, J. M. (2004). Risk and protective factors for alcohol and other drug use in childhood and adolescence. In M. W. Fraser (Ed.), *Risk and resilience in childhood: An ecological perspective* (2nd ed., pp. 183–208). NASW Press.

Jenson, J. M. (2018, May 1). *Seven ways to unleash the power of prevention*. Keynote presentation at the Blueprints for Healthy Youth Development Conference in Denver, Colorado, United States.

Jenson, J. M. (2020). Improving behavioral health in young people: It is time for social work to adopt prevention. *Research on Social Work Practice*, *30*, 707–711.

Jenson, J. M., & Bender, K. A. (2014). *Preventing child and adolescent behavior. Evidence-based strategies in schools, families, and communities*. Oxford University Press.

Jenson, J. M., & Hawkins, J. D. (2018). Ensuring healthy development for all youth: Unleashing the power of prevention. In R. Fong, J. Lubben, & R. P. Barth (Eds.), *Grand challenges for social work and society: Social progress engineered by science* (pp. 18–35). Oxford University Press.

Jenson, J. M., Potter, C. C., & Howard, M. O. (2001). American juvenile justice: Recent trends and issues in youth offending. *Social Policy and Administration*, *35*, 48–68.

Kaiser Family Foundation. (2018). *Abstinence education programs: Definition, funding, and impact on teen sexual behavior*. https://www.kff.org/womens-health-policy/fact-sheet/abstinence-education-programs-definition-funding-and-impact-on-teen-sexual-behavior/

Kaza, S., Yao, L., Bhada-Tata, P., & Van Woerden, F. (2018). *What a waste 2.0: A global snapshot of solid waste management to 2050*. World Bank.

Kohler, P. K., Manhart, L. E., & Lafferty, W. E. (2008). Abstinence-only and comprehensive sex education and the initiation of sexual activity and teen pregnancy. *Journal of Adolescent Health*, *42*(4), 344–351.

Kondrat, M. E. (2013). Person-in-environment. In C. Franklin (Ed.), *Oxford research encyclopedia of social work*. National Association of Social Workers Press and Oxford University Press.

Kuklinski, M. R. (2015). Benefit–cost analysis of prevention and intervention programs for youth and young adults: Introduction to the special issue. *Journal of Benefit–Cost Analysis*, *6*(3), 455–470.

Landrigan, P. J., & Goldman, L. R. (2011). Children's vulnerability to toxic chemicals: A challenge and opportunity to strengthen health and environmental policy. *Health Affairs*, *30*(5), 842–850.

Lanier, P., Maguire-Jack, K., Lombardi, B., Frey, J., & Rose, R. A. (2018). Adverse childhood experiences and child health outcomes: Comparing cumulative risk and latent class approaches. *Maternal and Child Health Journal*, *22*(3), 288–297.

Luthar, S. S. (2003). *Resilience and vulnerability: Adaptation in the context of childhood adversities*. Cambridge University Press.

Manlove, J., Fish, H., & Moore, K. A. (2015). Programs to improve adolescent sexual and reproductive health in the US: A review of the evidence. *Adolescent Health, Medicine and Therapeutics*, *6*, 47–79.

Marshal, M. P., Dietz, L. J., Friedman, M. S., Stall, R., Smith, H. A., McGinley, J., Thoma, B. C., Murray, P. J., D'Augelli, A. R., & Brent, D. A. (2011). Suicidality and depression disparities between sexual minority and heterosexual youth: A meta-analytic review. *Journal of Adolescent Health*, *49*(2), 115–123.

Martuzzi, M., Mitis, F., & Forastiere, F. (2010). Inequalities, inequities, environmental justice in waste management and health. *European Journal of Public Health*, *20*(1), 21–26.

Mason, L. R., & Rigg, J. (Eds.). (2018). *People and climate change: Vulnerability, adaptation, and social justice*. Oxford University Press.

Mattson, G., Kuo, D. Z., & Committee on Psychosocial Aspects of Child and Family Health. (2019). Psychosocial factors in children and youth with special health care needs and their families. *Pediatrics*, *143*(1).

McCrea, K. T., Richards, M., Quimby, D., Scott, D., Davis, L., Hart, S., Thomas, A., & Hopson, S. (2019). Understanding violence and developing resilience with African American youth in high-poverty, high-crime communities. *Children and Youth Services Review*, *99*, 296–307.

McKinlay, J. B. (1998). Paradigmatic obstacles to improving the health of populations: Implications for health policy. *Salud Pública de México*, *40*, 369–379.

McPherson, M., Arango, P., Fox, H., Lauver, C., McManus, M., Newacheck, P. W., Perrin, J. M., Shonkoff, J. P., & Strickland, B. (1998). A new definition of children with special health care needs. *Pediatrics*, *102*(1), 137–139.

Miller, T. R. (2004). The social costs of adolescent problem behavior. In A. Biglan, P. A. Brennan, S. L. Foster, & H. D. Holder (Eds.), *Helping adolescents at risk: Prevention of multiple problem behaviors* (pp. 31–56). Guilford Press.

Mohai, P., Pellow, D., & Roberts, J. T. (2009). Environmental justice. *Annual Review of Environment and Resources*, *34*, 405–430.

Mohai, P., & Saha, R. (2007). Racial inequality in the distribution of hazardous waste: A national-level reassessment. *Social Problems*, *54*(3), 343–370.

Mrazek, P. J., & Haggerty, R. J. (Eds.). (1994). *Reducing risks for mental disorders: Frontiers for preventive intervention research*. National Academies Press.

Munoz, R. F., Mrazek, P. J., & Haggerty, R. J. (1996). Institute of Medicine report on prevention of mental disorders: Summary and commentary. *American Psychologist*, *51*(11), 1116.

National Academies of Sciences, Engineering, and Medicine. (2019a). *The promise of adolescence: Realizing opportunity for all youth*. The National Academies Press.

National Academies of Sciences, Engineering, and Medicine. (2019b). *Fostering healthy mental, emotional, and behavioral development in children and youth: A national agenda*. The National Academies Press.

National Association of Social Workers. (2017). *Code of ethics*. https://www.socialworkers.org/About/Ethics/Code-of-Ethics/Code-of-Ethics-English

National Council on Family Relations. (1998). *NCFR ethical principles and guidelines for family scientists*. https://www.ncfr.org/board-and-governance/governance/ncfr-ethical-principles-guidelines-family-scientists

National Council on Family Relations. (2018). *Code of professional ethics for certified family life educators*. https://www.ncfr.org/cfle-certification/cfle-code-ethics

National Education Association. (2020). *Code of ethics*. https://www.nea.org/resource-library/code-ethics

National Museum of African American History & Culture. (2020). *Social identities and systems of oppression*. https://nmaahc.si.edu/learn/talking-about-race/topics/social-identities-and-systems-oppression

National Museum of the American Indian. (2007). *Native languages*. Smithsonian Institution.

Newport, F. (2018). *In U.S., estimate of LGBT population rises to 4.5%*. Gallup.

O'Connell, M. E., Boat, T., & Warner, K. E. (Eds.). (2009). *Preventing mental, emotional, and behavioral disorders among young people: Progress and possibilities*. National Research Council and Institute of Medicine; the National Academies Press.

Oesterle, S., Kuklinski, M. R., Hawkins, J. D., Skinner, M. L., Guttmannova, K., & Rhew, I. C. (2018). Long-term effects of the communities that care trial on substance use, antisocial behavior, and violence through age 21 years. *American Journal of Public Health*, *108*(5), 659–665.

Organisation for Economic Co-operation and Development. (2020). *National accounts of OECD countries*. OECD Publishing.

Petrova, D., & Garcia-Retamero, R. (2015). Effective evidence-based programs for preventing sexually transmitted infections: A meta-analysis. *Current HIV Research*, *13*(5), 432–438.

Pew Research Center. (2015a). *Parenting in America: Outlook, worries, aspirations are strongly linked to financial situation*. Author.

Pew Research Center. (2015b). *The American middle class is losing ground*. Author.

Pollard, J. A., Hawkins, J. D., & Arthur, M. W. (1999). Risk and protection: Are both necessary to understand diverse behavioral outcomes in adolescence? *Social Work Research*, *23*, 145–158.

Protected Planet. (2020). *United States of America, North America*. https://www.protectedplanet.net/country/US

Puzzanchera, C. (2020). *Juvenile arrests, 2018*. Office of Juvenile Justice and Delinquency Prevention, U.S. Department of Justice.

Quacquarelli Symonds. (2019). *The strongest higher education systems by country*. https://www.qs.com/the-strongest-higher-education-systems-by-country-overview/

Reinhart, R. J. (2018). *Global warming age gap: Younger Americans most worried*. Gallup.

Rickwood, D. J., & Thomas, K. A. (2019). *Mental wellbeing risk & protective factors*. Sax Institute.

Rosen-Reynoso, M., Porche, M. V., Kwan, N., Bethell, C., Thomas, V., Robertson, J., Hawes, E., Foley, S., & Palfrey, J. (2016). Disparities in access to easy-to-use services for children with special health care needs. *Maternal and Child Health Journal*, *20*(5), 1041–1053.

Rutter, M. (2012). Resilience as a dynamic concept. *Development and psychopathology*, *24*(2), 335–344.

Saad, L. (2019). *Americans as concerned as ever about global warming*. Gallup.

Sameroff, A. J. (2000). Developmental systems and psychopathology. *Development and Psychopathology*, *12*(3), 297–312.

Scanlon, R. (2019). *The generational divide over climate change*. The Chicago Council on Global Affairs.

Semega, J., Kollar, M., Creamer, J., & Mohanty, A. (2020). *Income and poverty in the United States: 2018*. U.S. Census Bureau.

Sexuality Information and Education Council of the United States. (2019). *A history of abstinence-only funding in the U.S.* https://siecus.org/resources/a-history-of-abstinence-only-federal-funding/

Society for Prevention Research. (2020). *Code of conduct: Society for Prevention Research*. https://www.preventionresearch.org/about-spr/code-of-conduct-society-for-prevention-research/

Society for Social Work and Research. (2020). *SSWR anti-harassment policy and code of ethics and procedures for review of member conduct*. https://secure.sswr.org/about-sswr/sswr-anti-harassment-policy/

Sullivan, P. F., Daly, M. J., & O'Donovan, M. (2012). Genetic architectures of psychiatric disorders: the emerging picture and its implications. *Nature Reviews Genetics*, *13*(8), 537–551.

Underhill, K., Operario, D., & Montgomery, P. (2007). Abstinence-only programs for HIV infection prevention in high-income countries. *Cochrane Database of Systematic Reviews*, *4*, 1–143.

Ungar, M. (2011). The social ecology of resilience. Addressing contextual and cultural ambiguity of a nascent construct. *American Journal of Orthopsychiatry*, *81*, 1–17.

U.S. Bureau of Labor Statistics. (2020a). *College enrollment and work activity of recent high school and college graduates summary*. https://www.bls.gov/news.release/hsgec.nr0.htm

U.S. Bureau of Labor Statistics. (2020b). *Employment characteristics of families*. Author.

U.S. Census Bureau. (2007). *First, second, and total responses to the ancestry question by detailed ancestry code: 2000*. https://www.census.gov/data/tables/2000/dec/phc-t-43.html

U.S. Census Bureau. (2019). *Population estimates, July 1, 2019*. https://www.census.gov/quickfacts/fact/table/US/PST045219

Vespa, J., Medina, L., & Armstrong, D. M. (2020). *Demographic turning points for the United States: Population projections for 2020 to 2060*. U. S. Census Bureau.

Vloet, T. D., Vloet, A., Bürger, A., & Romanos, M. (2017). Post-traumatic growth in children and adolescents. *Journal of Traumatic Stress Disorders & Treatment*, *6*(2), 1–7.

Wang, K., Chen, Y., Zhang, J., & Oudekerk, B. A. (2020). *Indicators of school crime and safety: 2019*. National Center for Education Statistics, U.S. Department of Education, and Bureau of Justice Statistics, Office of Justice Programs, U.S. Department of Justice.

Wang, Q. (2005). *Disability and American families: 2000*. U.S. Census Bureau.

Werner, E. E. (1989). Vulnerability and resiliency: A longitudinal perspective. In M. Brambring, F. Lösel, & H. Skowronek (Eds.), *Children at risk: Assessment, longitudinal research, and intervention* (pp. 158–172). Walter de Gruyter GmbH.

Williams, R., & Leahy, A. (2019). *Ranking of national higher education systems 2019*. Universitas21.

World Health Organization (WHO). (1948). *Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York*, June 19–22, 1946. Author.

World Health Organization (WHO). (2014). *The case for investing in public health*. https://www.euro.who.int/__data/assets/pdf_file/0009/278073/Case-Investing-Public-Health.pdf

World Health Organization (WHO). (2020). *Health promotion*. https://www.who.int/healthpromotion/healthy-settings/en/

Young, I. M. (2018). Five faces of oppression. In M. Adams, W. J. Blumenfeld, D. C. J. Catalano, K. S. DeJong, H. W. Hackman, L. E. Hopkins, B. J. Love, M. L. Peters, D. Shlasko, & X. Zuniga (Eds.), *Readings for diversity and social justice* (4th ed., pp. 49–58). Routledge.

2

ANTI-POVERTY POLICIES AND PROGRAMS FOR CHILDREN AND FAMILIES

Trina R. Williams Shanks, Sandra K. Danziger, and Patrick J. Meehan

Poverty is a risk factor for many problems experienced by children and youth. Evidence from various disciplines indicates that children growing up in low-income households experience social and health conditions that place them at risk for later academic, employment, and behavioral problems (Conley, 1999; Davis-Kean, 2005; Duncan et al., 2010; Ekono et al., 2016; Guo & Harris, 2000; Hair et al., 2016; Hanson et al., 2013; McLoyd, 1998; Sampson et al., 2002; Williams Shanks & Robinson, 2013; Yoshikawa et al., 2012). Indeed, the detrimental influence of poverty is apparent in all of the substantive policy areas discussed in this book.

Children are poor because they reside in households and/or communities that are poor. Thus, a principal goal of anti-poverty policies is to break the link between poor resources of parents or caregivers and adverse child outcomes. To achieve this goal, some anti-poverty policies and programs provide material support to parents to reduce the pressures they face. Other anti-poverty initiatives offer resources and opportunities directly to children to build their personal capabilities. Evidence suggests that the specific targets of social policy should not be an "either–or" proposition or strategy. That is, studies show that it is important both to support low-income parents and to promote child well-being (Chase-Lansdale & Brooks Gunn, 2014; Haskins et al., 2014; Waldfogel, 2006; Waters Boots et al., 2008).

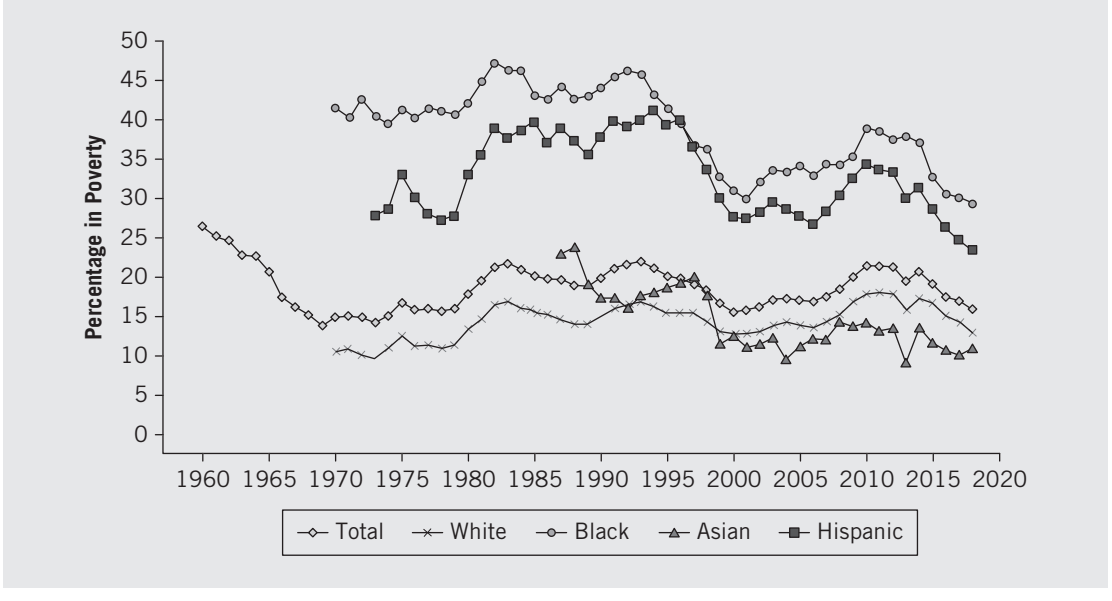
In this chapter, we examine risk and protective factors associated with childhood and adolescent poverty. Major income-assistance and income-maintenance policies for children and families are reviewed. Trends in anti-poverty policy are noted; particular emphasis is paid to the trends related to the COVID-19 pandemic. We note how poverty in the United States (U.S.) and American social policies aimed at ameliorating childhood poverty compare with approaches in other industrialized countries. Finally, we consider ways to improve on available options in the U.S. by making policies and programs more comprehensive and with greater integration of services to promote better outcomes for all children and families.

Sadly, the year 2020 will forever be remembered for the COVID-19 pandemic. In addition to infecting more than 6 million Americans and killing more than 200,000 in its first eight months, it has wreaked disproportional havoc on the lives of the nation's most vulnerable families. Millions of low-income children saw their lives immeasurably altered through the physical and emotional trauma of contracting COVID-19 themselves, witnessing the illness in a loved one, and loss of family income. As a society, we will be feeling the impacts on their disrupted emotional development and educational attainment for decades. The consequences of the pandemic in both the short and long run are compounded by having further exacerbated preexisting economic disparities.

PREVALENCE AND TRENDS IN POVERTY

The debate about the best way to measure poverty is long and ongoing (Blank, 2008; Couch & Pirog, 2010). To bring some unity to the study of poverty, the U.S. Census Bureau in the 1960s established income thresholds based on before-tax cash sources to determine whether a household is officially poor. These thresholds are updated annually. As shown in Figure 2.1, child poverty rates reached a low during the late 1960s

Figure 2.1 Child Poverty Rates in the United States by Race and Ethnicity, 1960–2018



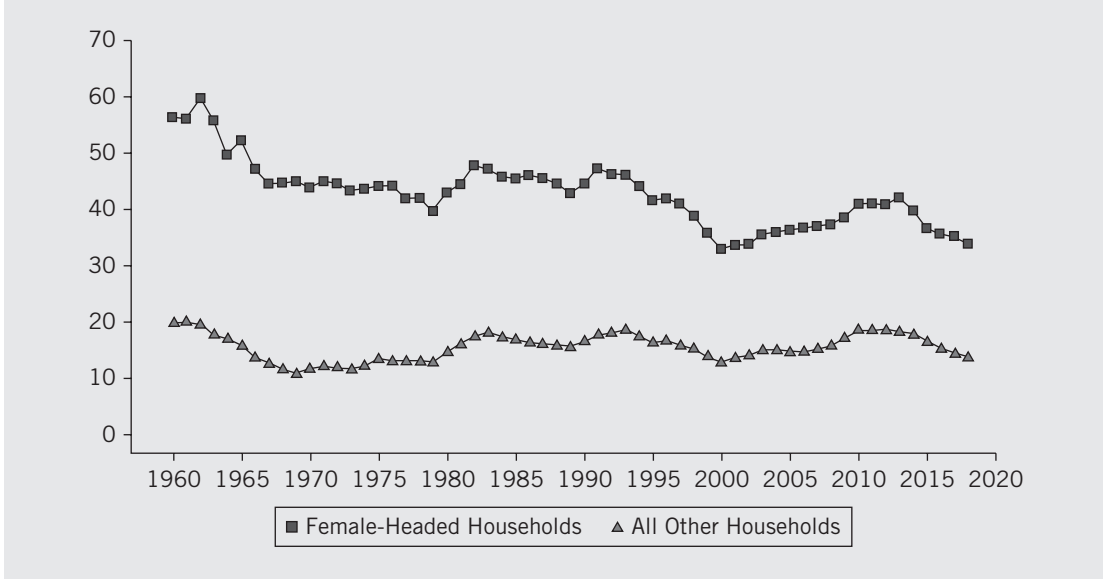
Source: U.S. Census Bureau (2020a). https://www.census.gov/data/tables/time-series/demo/income-poverty/historical-poverty-people.html

to early 1970s. Since then, child poverty rates have fluctuated with periodic increases and decreases. Nearly 23% of all children under the age of 18 lived in poverty in 1993; child poverty declined between 1993 and 2002, increased through the Great Recession, then began to decrease again. In 2018, 16.2% of children lived in poverty and, according to the new census report on 2019 (Semega et al., 2020), it decreased again to 14.4% due to lower unemployment rates. But several reports estimate that these gains will have been wiped out by the pandemic in 2020 (see for example, Parolin & Wimer, 2020).

The average poverty rate hides considerable variation by race and ethnicity, as shown in Figure 2.1. Although rates have gone down in the past decade, Black and Hispanic children continue to be twice as likely to be poor compared with Asian and non-Hispanic White children. As shown in Figure 2.2, children residing in female-headed households experience poverty at four times the rate of all other households. These poverty disparities remain high amidst declining child poverty overall.

The 2020 growth of poverty and hardship due to the pandemic has shown steep rises, particularly among families of color. A report by Saenz and Sherman (2020) uses census data to find that from February to May 2020, the number of White children in families with below-poverty earnings rose 17%; for Black children, 27%; and for Hispanic/Latinx children, 29%. Worse yet, the percentage of children living with no earnings rose 30% for Whites, 29% for Blacks, and 58% for Hispanics.

Figure 2.2 Child Poverty Rates by Household Type, 1960–2018



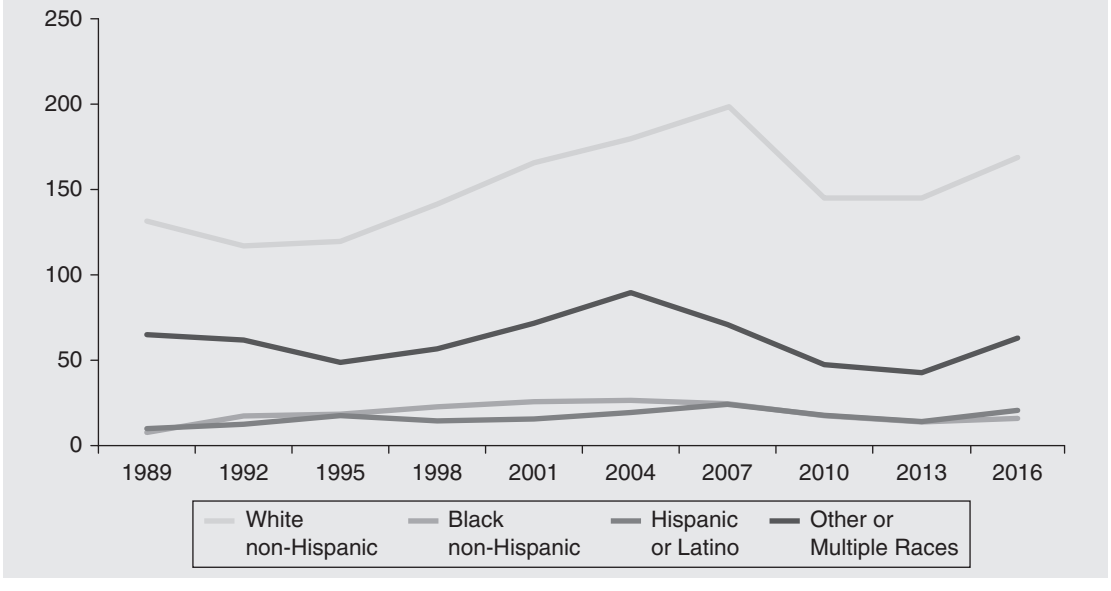
Source: U.S. Census Bureau (2020b). https://www.census.gov/data/tables/time-series/demo/income-poverty/historical-poverty-people.html

In spite of the widespread use of the Census Bureau definition and its use of the new Supplemental Poverty measure (Fox, 2018), the measurement of poverty continues to be debated. Critics charge that most surveys that measure income flows into a household miss an important aspect of a household's financial situation because they fail to consider family assets. For example, a family with housing equity, savings, and investments is in a better situation and has more favorable long-term prospects than a family of equal income but no assets. Although there is no official approach to measuring assets, researchers typically calculate assets by using household net worth (Brandolini et al., 2010; Haveman & Wolff, 2004; Shapiro et al., 2009).

Data reflecting household net worth reveal that racial and ethnic disparities in assets are even greater than disparities in income (Lui et al., 2006; Oliver & Shapiro, 1995; Shapiro, 2004; Sullivan et al., 2015). As shown in Figure 2.3, Black and Hispanic/Latinx households at times own about a tenth, respectively, of the median net worth of White households. Although most households faced declines in net worth after the recession of 2007 to 2009, White households have experienced a more rapid increase in net worth since 2013, exacerbating the inequality with Black and Hispanic/Latinx households. Furthermore, as depicted in Figure 2.4, households with children have the lowest levels of net worth. Couples with no children have the most wealth, followed by couples with children, followed by single-parent households with children at a distant third. These households have experienced almost no increase in wealth in the last decade.

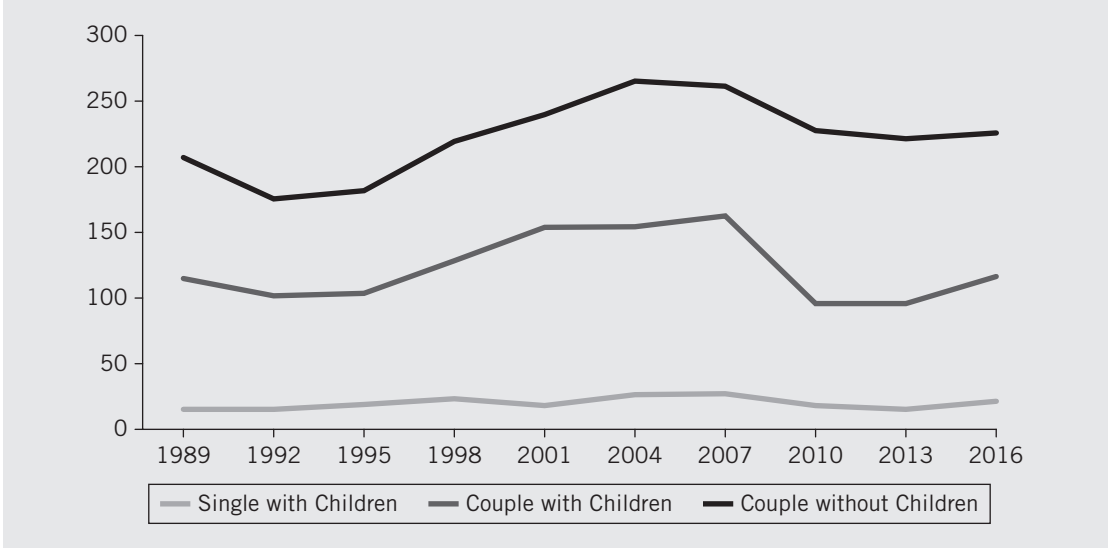
The situation is even worse when considering financial net worth, which excludes home equity and the value of vehicles. As many as 63% of families with children are

Figure 2.3 Median Net Worth by Race, 1989–2016 (in Thousands, 2016 Dollars)



Source: 2016 Survey of Consumer Finances. https://www.federalreserve.gov/econres/scfindex.htm

Figure 2.4 Median Net Worth by Household Types, 1989–2016 (in Thousands, 2016 Dollars)



Source: 2016 Survey of Consumer Finances. https://www.federalreserve.gov/econres/scfindex.htm

asset-poor according to this measure, meaning that they lack sufficient financial assets to sustain the household at the poverty line for three months (Rothwell et al., 2019). In fact, female-headed households with children had asset poverty rates as high as 77% in 2007 (Aratini & Chau, 2010).

For a brief moment, it appeared the coronavirus pandemic was reversing these trends. With much of the economy shut down during the spring of 2020, Americans saved money at greater rates than they had in decades (Fitzgerald, 2020). Survey data in the midst of the pandemic suggested a plurality of Americans planned to save more in an emergency fund going forward and to spend less on nonessentials (El Issa, 2020). Of course, much of the saving behavior was in response to job loss or sharply reduced incomes. Many low-income households, but especially those of color, were late with rent or mortgage payments during the pandemic (Ricketts, 2020). Existing inequality exacerbated the extent of the pandemic in the U.S. by making it more difficult for low-income workers to take time off or work from home to avoid exposure (Boushey & Park, 2020).

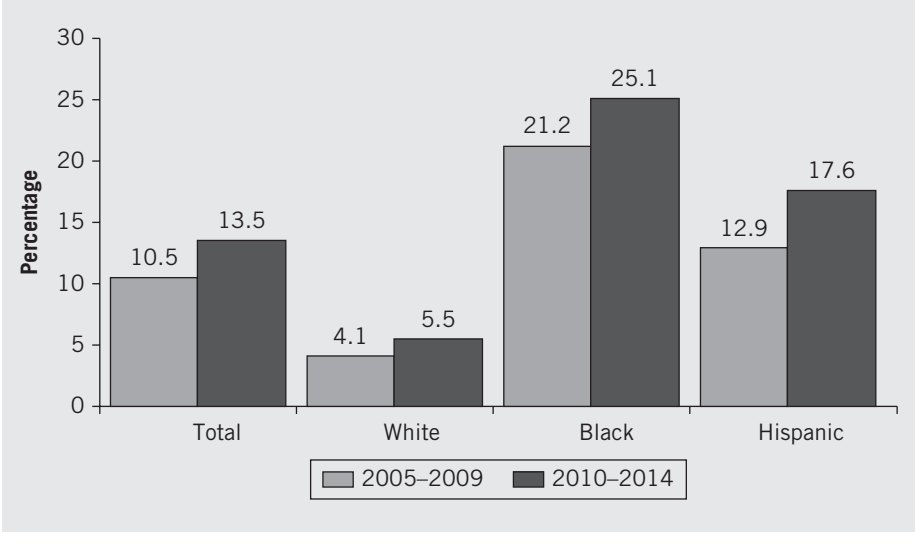
Another way to think about poverty is at the neighborhood or community level. *Neighborhood poverty* refers to the spatial concentration of poor households in neighborhoods, which are measured by census tracts. Generally, a poor neighborhood is one in which 20% to 40% of residents live below the poverty line. The concentration of the poor in high-poverty census tracts in the U.S. increased dramatically between 1970 and 1990 (Jargowsky, 2013).

In the early period, the growing concentration of poverty resulted from two main macroeconomic changes. First, a decline in manufacturing markets negatively impacted inner cities and resulted in an increase in urban poverty rates. Second, consistent with a systems of oppression perspective (discussed in Chapter 1), factors such as discrimination in the housing and lending markets and rapid suburban development increased racial and socioeconomic segregation such that inner-city neighborhoods became predominantly Black and poor (Jargowsky, 1997; Massey & Denton, 1993). The 1990s were also characterized by an increase in the share of neighborhood poverty that was in the suburbs. That is, poverty declined in all other areas, but the rates of suburban poverty remained stable (Jargowsky, 2003; Kingsley & Pettit, 2016).

The decline in neighborhood poverty between 1990 and 2000 may be explained by neighborhood fluctuations in poverty concentration (Kingsley & Pettit, 2016) and by decreases in overall poverty caused by the improving economy of the late 1990s (Jargowsky, 2003). Recent evidence suggests that the economic decline since 2000 and especially during the Great Recession has led to a new increase in poverty—both nationally and in isolated neighborhood settings. Suburban poverty has continued to grow, especially in western and Sun Belt states, and neighborhood poverty has also increased in midwestern cities and suburbs in recent years (Kneebone & Garr, 2010).

People of color experience community-level poverty at much higher rates than Whites. Figure 2.5 is taken from Kneebone and Holmes (2016) to show the distribution of concentrated poverty by race in the U.S. Such neighborhoods are defined as having a poverty rate of 40% or more. More than one quarter of African Americans

Figure 2.5 Concentrated Poverty Rate by Race and Ethnicity



Source: (Kneebone & Holmes, 2016), Brookings Institution analysis of American Community Survey data

live in such neighborhoods. This disparity is even greater among children (Jargowsky, 2003; Sharkey, 2009). Only 1% of White children born between 1955 and 1970 lived in poor neighborhoods, whereas 29% of Black children born during this time lived in poor neighborhoods at some point in their childhood. About 31% of Black children born between 1985 and 2000 experienced neighborhood poverty (Sharkey, 2009). Inequality and poverty in neighborhood contexts for children expose them to serious risks that often compromise normal and healthy development.

POVERTY, RISK, AND PROTECTION

There are many frameworks theorizing how poverty is related to child outcomes and why low-income youth have worse outcomes than their nonpoor peers. The person-in-environment risk and resilience framework (discussed in Chapter 1) considers the interpersonal and other environmental factors that influence a child in increasingly wider spheres as well as the interactions between the spheres of influence. The communities and institutions that a child interacts with on a regular basis as well as the policies and cultural ideologies that shape them establish the foundation for who the child evolves to become over time.

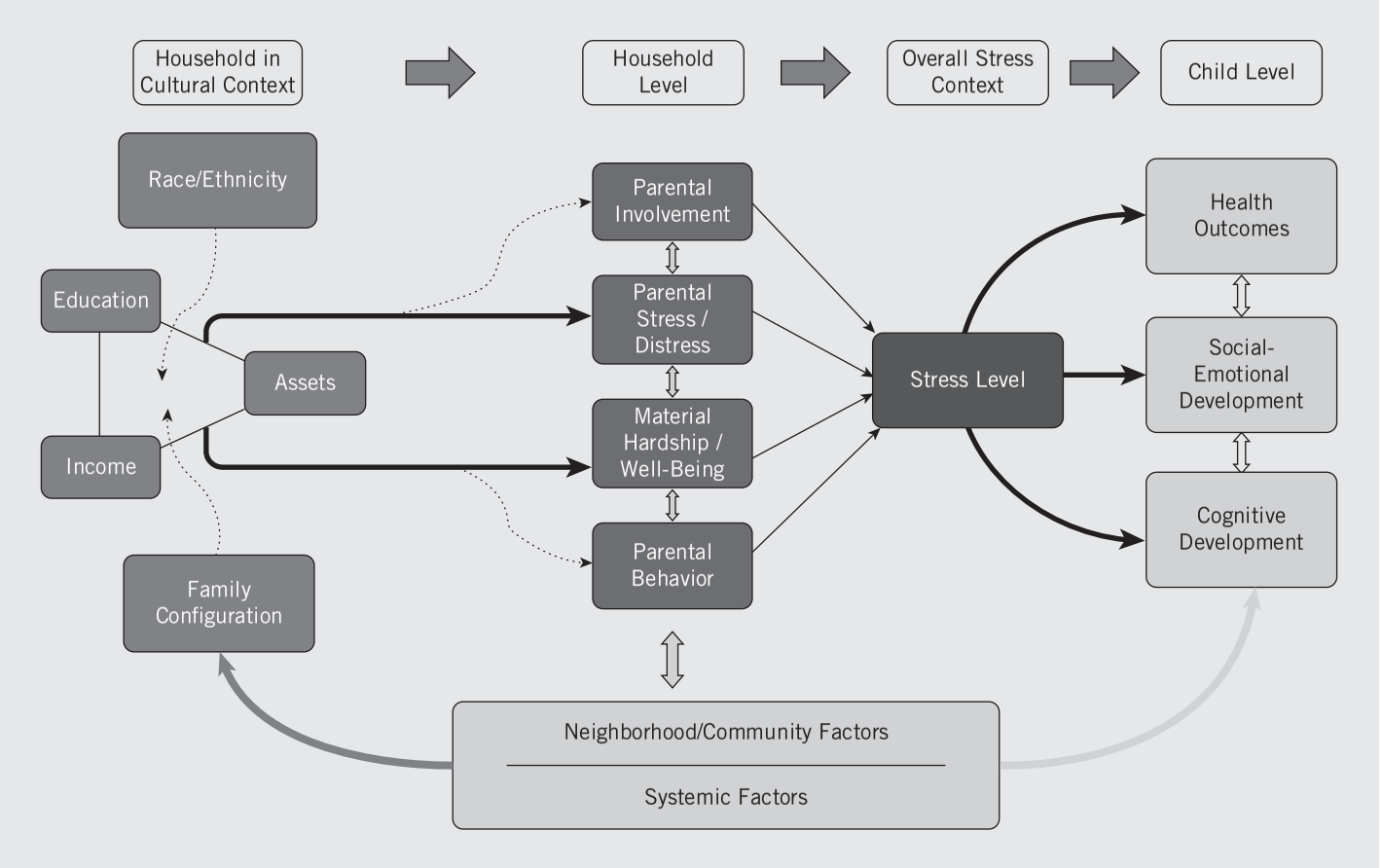
The mechanisms through which environmental factors associated with poverty and economic inequality influence child outcomes can be complex. Figure 2.6 shares a framework developed by Williams Shanks and Robinson (2013) on how various socioeconomic factors interact to influence child-level outcomes. The model begins with the wider cultural and societal context. There are predictable ways that race, ethnicity, gender dynamics, and family formation intersect with structural barriers and institutional norms to expand or limit the likelihood of attaining family-sustaining levels of income, wealth, and education.

Economic resources then shape household-level relationships such as parental involvement and behavior and, even more directly, the degree of economic stress and material hardship experienced within the home. Simultaneously, economic resources influence residential stability and the type of neighborhood in which a child resides. It could be one with high-quality schools and an array of community resources or a situation where the child feels unsafe and experiences multiple traumas. All of these elements combine systematically to influence child outcomes and delimit the likelihood that caring adults are present to mitigate any negative circumstances that arise.

Interpersonal and Social Risk Factors

Family economic security is a necessary foundation for promoting emotionally responsive parent–child relationships and child well-being. Families living in poverty and struggling to make ends meet will have a more difficult time developing strong bonds with their infants and children because they must also deal with the daily stresses of trying to support basic needs. This includes not only having employment pathways but also economic assets to rely on when times are challenging.

Figure 2.6 Neighborhood/Community Factors and Systemic Factors



Source: Shanks, T. R. & Robinson, C. (2013)2. Assets, economic opportunity and toxic stress: A framework for understanding child and educational outcomes. *Economics of Education Review.*

Although there are many gaps in public programs, states, counties, and other entities often have opportunities to exercise discretion in the implementation of social policies and, as a result, to experiment with new ways to support parent–child relationships among low-income families receiving public assistance. For example, the federal Temporary Assistance for Needy Families (TANF) program gives states the option to exempt single parents from work requirements for up to 12 months if they have a child under the age of 1 (Schott & Pavetti, 2013). Many states have adopted this provision in the TANF program, but wide variability across states exists in the number of months that new parents are provided exemptions. In Michigan, for example, TANF cash assistance recipients are given a two-month exemption period after the birth of a child. In 2018, the variation across states was between 0 and 12 months, according to the Welfare Rules Database (Urban Institute, 2020).

Clearly, the parent–infant bonding period in those first days and months lays the groundwork for a strong parent–child relationship and child development and well-being. Federal TANF policy could improve its support of the parent–infant relationship by mandating that states provide a minimum number of months of work exemption after the birth of a baby. Above and beyond these regulations, federal law could require that states offer an evidenced-informed home-visiting service to families, one that includes infant mental health support for optimal outcomes (Condon, 2019). Similarly, workforce development agencies could consider policies to better support the parent–infant relationship that looks at pairing workforce skill-building opportunities with services that promote the parent–child relationship and child well-being. A 2016 federal report offered guidelines to states for how they might strengthen family support services for TANF families (strengthening TANF outcomes by developing two-generation approaches to building economic security, TANF-ACF-IM-2016-03).

Evidence for the need for such linkages has emerged in recent years. For example, using a nationally representative longitudinal household survey, Shaefer and colleagues (2018) replicated the adverse childhood experiences (ACEs) studies conducted largely with patient records. By linking detailed early family income measures with retrospective reports of early family circumstances and adult well-being, they found that (a) ACE exposure is negatively correlated with childhood income so that higher income in childhood reduces the likelihood of a child experiencing such events as physical abuse, domestic violence, parental depression, and drug violence; (b) exposure to both low income and ACEs exert independent effects on adult socioeconomic and health outcomes; and (c) higher income in childhood may dampen the relationship between exposure to ACEs and some long-term outcomes, including educational attainment, arrest, lung disease, and possibly poverty and smoking. The study concluded that combining early childhood anti-poverty policies together with early intervention family support/infant mental health policies could strengthen long-term human capital and promote overall child well-being.

During the COVID-19 pandemic, low-income children were at greater risk of infection (Goyal et al., 2020), and they were more likely to have had family members die (Drayton, 2020). Cabildo, Graves, Kim, and Russo (2020), for example, found that

in Los Angeles, neighborhoods with a higher percentage of residents under 200% of poverty had 3.2 times as many COVID-19 infections as neighborhoods with a lower percentage of residents in poverty. Given that familial death and disease are traumatic experiences, the developmental consequences of the COVID-19 pandemic may be particularly harmful for a generation of low-income children.

Environmental Risks

In now-classic studies, Wilson (1987, 2009) found that concentrated neighborhood poverty isolates poor residents and limits their exposure to positive role models, employment networks, and community resources. A large body of research has examined the direct and indirect effects of neighborhood poverty on child and adolescent outcomes (Harding, 2003; Hart et al., 2008; Kling et al., 2005; Leventhal & Brooks-Gunn, 2000; Pachter et al., 2006). Many investigators have emphasized the significant and adverse effects of limited local resources and opportunities on children's development. Poor neighborhoods tend to lack quality institutions and social services (Leventhal & Brooks-Gunn, 2000; Sampson et al., 2002). Children growing up in poor neighborhoods witness frequent acts of violence and experience considerable chaos, disorder, and isolation. In such communities, parental stress and a lack of support services negatively affect developmental outcomes in children and youth (Klebanov et al., 1994; Kohen et al., 2008; McLoyd, 1998; Patton et al., 2012; Williams Shanks & Robinson, 2013).

Much research has documented the escalating trend in mass incarceration and its unequal impacts on poor communities and especially on urban communities of color. Loury (2010), for example, noted the "ubiquity" of the impact of criminal justice practices and policies on the incarceration of low-income men, reporting that in some neighborhoods, 1 in 5 adult men may be behind bars on any given day. According to Clear (2009), having so many young men go in and out of jails and prisons is "a central factor determining the social ecology of poor neighborhoods" (p. 10). Research has attempted to disentangle the effects of parental incarceration from the effects of other family and community risk factors in terms of the impact on children (e.g., Wildeman & Turney, 2014; Wildeman & Western, 2010). According to a 2017 National Institute of Justice report, "children whose parents are involved in the criminal justice system, in particular, face a host of challenges and difficulties: psychological strain, antisocial behavior, suspension or expulsion from school, economic hardship, and criminal activity" (Martin, 2017, p. 1). The impacts of disproportionate incarceration are widely felt at the neighborhood, school, and community levels and should be considered when mapping strategies for the implementation of social policies for children, youth, and families.

The causal impact of neighborhood economic quality on long-term child outcomes has been powerfully demonstrated in the recent work of economist Raj Chetty and colleagues (Chetty, n. d.; Chetty et al., 2014; Chetty et al., 2016). By examining the tax records of adults who moved across counties during childhood, they find that the areas in which children grow up affect their prospects for long-term economic mobility, including income, college attendance, and the prospects of teen pregnancy. The characteristics of neighborhoods that have higher rates of upward economic mobility include less segregation by race and income, lower levels of income inequality, better

schools, lower rates of crime, and a larger share of two-parent households. Chetty and colleagues (2014) argue for policies to help move families to better neighborhoods and policies to reduce segregation and concentrated poverty.

ANTI-POVERTY POLICIES AND PROGRAMS

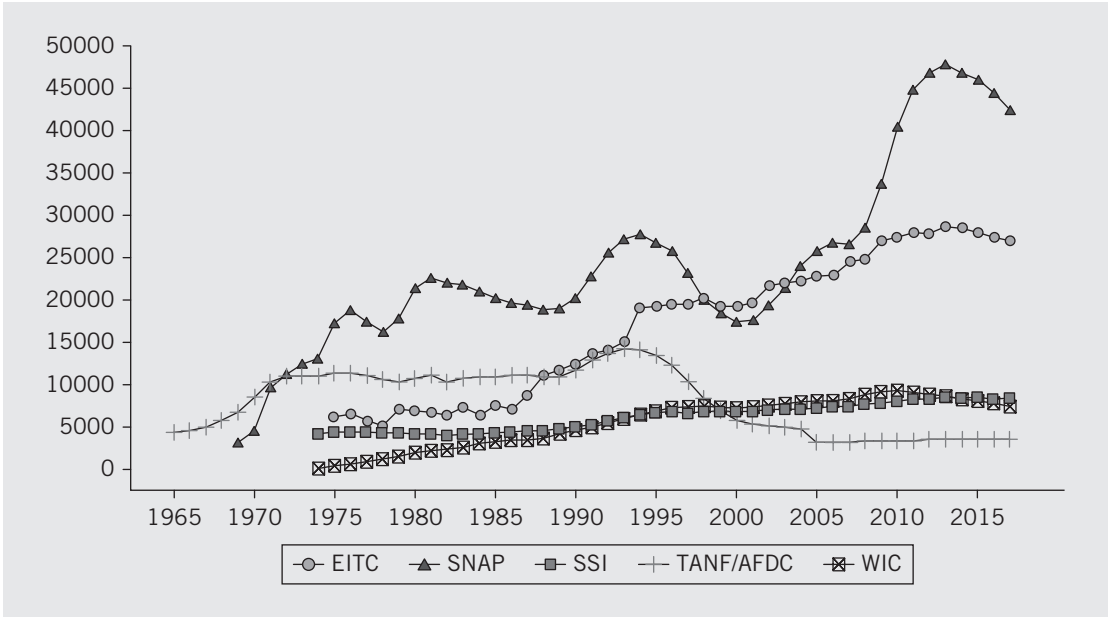
The U.S. has never instituted a comprehensive federal response to child poverty. In fact, no federal role in cash aid to poor children and families existed prior to 1935; only assistance from state, local, and private charities was available. Even today, with an array of federal anti-poverty programs, no policy or program reaches everyone who is eligible, and typically, no priority is given to social development or economic mobility (Williams Shanks, 2014). Although critically important to child well-being, we exclude health insurance, medical care, and educational programs because these topics are covered in other chapters. Table 2.1 provides an overview of some of the major federal programs that offer support for the basic needs of low-income children; participation levels in the major anti-poverty programs between 1960 and 2018 are shown in Figure 2.7.

A helpful way of contextualizing America's commitment to low-income children and families is to understand the difference between federal entitlement programs and those that are at the discretion of state governments. Entitlement programs "require payments to any person . . . that meets the eligibility criteria established by law" (U.S. Senate, n. d.). Moreover, "entitlements constitute a binding obligation on the part of the Federal Government, and eligible recipients have legal recourse if the obligation is not fulfilled." Entitlements thus represent a strong, open-ended commitment to eligible recipients. Who deserves to be an eligible recipient of an open-ended entitlement is contested, and over the decades, there have been many attempts to eliminate or chip away at entitlements in favor of greater devolution and discretion to state governments.

The first federal welfare program, Aid to Dependent Children (ADC), was an open-ended entitlement to low-income mothers with children. Included in the 1935 Social Security Act, the name of the program changed at midcentury to Aid to Families with Dependent Children (AFDC). Participation peaked at 15 million in 1994 amidst backlash toward so-called "welfare queens" and racial stigma directed at beneficiaries. The Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA, Public Law No. 104-93), signed by President Clinton in August 1996, ended AFDC's 60-year history of open-ended entitlement of income support to low-income children and families. Compared with AFDC, the new TANF plays a smaller role as a resource for families.

Several rules restrict participation in TANF, including lifetime time limits for receipt of benefits and, although states are afforded some options for implementation, a mandatory work requirement. States are required to impose sanctions in the form of benefit reduction or case closure to families who do not comply with requirements. States can implement diversion programs to deter or deflect applicants from entering the program (e.g., providing a one-time lump-sum payment to families who agree not to seek cash benefits for a set period of time). TANF disallows parents with a drug felony conviction from receiving benefits, and it requires teenage parents under the age of 18 to live with an adult and attend school as a condition of receiving benefits. New legal immigrants

Figure 2.7 Federal Anti-Poverty Program Participation, 1965 to 2018



Note: EITC refers to the Earned Income Tax Credit; SNAP refers to the Supplemental Nutrition Assistance Program; TANF/AFDC refers to Temporary Assistance for Needy Families/Aid to Families with Dependent Children; WIC refers to Women, Infants, and Children.

Sources: U.S. Department of Agriculture (2020b). https://www.fns.usda.gov/pd/supplemental-nutrition-assistance-program-snap. U.S. Department of Agriculture (2020a). https://www.fns.usda.gov/pd/wic-program. Internal Revenue Service (2020c). http://www.irs.gov/uac/SOI-Tax-Stats-Historical-Table-1. Internal Revenue Service (2020d). https://www.irs.gov/statistics/soi-tax-stats-individual-statistical-tables-by-size-of-adjusted-gross-income. Social Security Administration (2019a). https://www.ssa.gov/policy/docs/statcomps/supplement/2018/. U.S. Department of Health and Human Services (2019a). https://www.acf.hhs.gov/ofa/resource/tanf-and-afdc-historical-case-data-pre-2012. U.S. Department of Health and Human Services (2019c). https://www.acf.hhs.gov/ofa/resource/tanf-caseload-data-1996-2012.

are not allowed to receive means-tested public benefits, including TANF, for the first five years after entry, according to testimony from Michael Fix of the Migration Policy Institute to the U.S. House Committee on Ways and Means (Fix, 2006).

Neither the critics' dire predictions of increased child poverty nor the proponents' rosy forecasts that children would directly benefit from seeing their mothers take jobs came true in the first decade after the 1996 welfare reform (Danziger, 2010). Studies did not find that welfare leavers had improvements in terms of stress levels and mental health status as they exited the rolls nor did the lives of children improve as a result of welfare reform and increases in the employment of mothers (Danziger, 2010; Edin & Kissane, 2010).

The proportion of families with children in poverty who received benefits fell from 81.6% in 1995 (before the 1996 reform) to 16.8% in 2007 (before the Great Recession;

Congressional Research Service, 2019). As shown in Figure 2.7, the rolls did not rise during or after the recession, despite rising poverty rates. Administrative data from September 2019 indicate that the average number of children in receipt of TANF benefits per month was 1.6 million (Congressional Research Service, 2020). In that year, according to the census poverty report, 10.5 million people aged 18 and under were poor.

In addition, the value of TANF benefits have fallen in inflation-adjusted terms since 1996 (Center on Budget and Policy Priorities, 2020). In 2018, the maximum monthly benefit for a parent with two children ranged from $170 in Mississippi to $1,039 in New Hampshire (Congressional Research Service, 2020). By 2020, in a median state, a family of three received $486 per month (Safawi & Floyd, 2020).

Normatively, AFDC's transition to TANF signaled that low-income families and children were not deserving of an open-ended entitlement to income support. The only other program that offers a cash entitlement to low-income children and families is Supplemental Security Income (SSI). Children under 18 years of age who are blind or have a severe physical or mental impairment are eligible to receive SSI benefits. In 2020, the average monthly benefit for a disabled child was $783 (Social Security Administration, 2020). Recent participation among eligible children has receded from the 2013 high of 1.3 million. Importantly, many children and families experience long delays in the application and review process (U.S. Government Accountability Office, 2009).

The Supplemental Nutrition Assistance Program (SNAP; H.R. 2419, the Food, Conservation, and Energy Act of 2008) is an entitlement of a different sort. SNAP provides food assistance in the form of electronic benefits transfer (EBT) cards, which function as debit cards at retail grocery stores. This in-kind form of support supplements a recipient's income but cannot be converted to cash and can only be used on eligible products. Notably, SNAP does not cover feminine hygiene products or diapers. The average monthly per-person benefit in 2019 was $130 (Food and Nutrition Service, 2020a). The maximum monthly benefit for a family with two adults and three children in 2020 was $768. As shown in Figure 2.7, the rate of participation in SNAP rose dramatically from 2000 to 2013, when it peaked at 47.6 million. However, only 37.9% of low-income (< 185% poverty level) children experiencing food insecurity receive SNAP. In 2020, the monthly number of households receiving SNAP went from 18.8 million in February (before the pandemic) to 22.2 million in April during the height of the first wave of COVID-19 infections (Food and Nutrition Service, 2020b).

The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) is a federal food-support program for low-income pregnant and postpartum women and their young children (U.S. Department of Agriculture, 2020a). However, states administer WIC and set their own eligibility requirements. Rather than an open-ended entitlement, states provide benefits to individuals through a limited block grant at their discretion. Similar to SNAP, participation in WIC peaked in 2013 at 9.1 million.

An increasingly important addition to anti-poverty efforts is the Earned Income Tax Credit (EITC), a refundable tax credit to low-income workers and their families. In 2019, 25 million families received income support through the federal EITC, down from a recent peak of 28.8 million in 2013. It is estimated that the program lifts 2.5 million children with working parents out of poverty each year (U.S. Department of

the Treasury, n. d.-a). For a single person with three or more dependent children, the maximum benefit was $6,660 in 2020 (Internal Revenue Service, 2020a). The maximum allowable income to receive any benefit is $56,844 (married filing jointly with three children or more), which is more than 200% of the federal poverty line. Some states and localities also have tax credits for working low-income families that supplement this program (Purmort, 2010). As Figure 2.7 shows, the number of households receiving the EITC began to exceed TANF participation in the early 1990s, when EITC federal policy expanded. EITC has now outstripped TANF as a source of income support, but it only is available for children with employed parents. Moreover, the 2017 Tax Cuts and Jobs Act changed how the rate of inflation was calculated so that credit increases grow at a slower rate than in previous years (Tax Policy Center, 2020).

The 1996 PRWORA expanded and consolidated federal funding for childcare for employed parents into the Child Care and Development Block Grant (CCDBG). Under this act, states are provided flexibility in determining income and work eligibility, structuring the voucher program, and determining which types and standards of care will be reimbursed at what rates. There is consistent evidence that subsidies facilitate employment of low-income and welfare recipient families (Bainbridge et al., 2003; Blau & Tekin, 2007; Danziger et al., 2004; Meyers et al., 2002; Press et al., 2006). Between 1997 and 2006, public funding for CCDBG more than doubled from $3.7 billion to $9 billion (U.S. House of Representatives, 2018). In 2018, 1.3 million children in 800,000 families received childcare vouchers. This was down from the 2001 peak of 1.8 million children in 1 million families. Although the majority of low-income families rely on childcare that is developmentally inadequate or minimally adequate (Levine Coley et al., 2006; Ryan et al., 2011), this is due in part to the low availability of high-quality care in low-income communities. It is also unclear whether subsidy receipt leads to higher-quality care (Antle et al., 2008; Ryan et al., 2011). Subsidies could be structured to promote use of higher-quality care, but the issue of greatest priority is access, as only 1 in 7 eligible children receive this assistance (Giannarelli et al., 2019). Even worse, since the pandemic caused widespread closure of childcare facilities and schools and high levels of unemployment (that disqualify parents from receiving subsidies), the need for out-of-home early care and education in low-income families is dire.

The federal government also supports the employment of youth and adults through training and education programs designed to ensure that participants are job ready. Although job-training programs were originally designed to assist dislocated workers, they became a part of federal anti-poverty strategies by the 1960s (LaLonde, 1995). Just as PRWORA shifted the focus of welfare toward "work first," the approach of job-training programs has also shifted toward employment. The Workforce Investment Act (WIA) of 1998 was enacted to replace the Job Training Partnership Act (JTPA), with an emphasis on job placement before training or education (Holzer, 2008). With the changes from the JTPA to WIA, substantially fewer low-income youth and adults received training. About 95% of program leavers (i.e., those whom local agencies recorded as having completed or exited the program) reported receiving some form of job training in JTPA compared to 68.4% of exiters from WIA in 2003 (Frank & Minoff, 2005). The Workforce Innovation and Opportunity Act (WIOA) of 2014 replaced WIA, but it did not appropriate funding to maintain training and education at existing