

Supreme Court No. 84132-2

No. 27394-6-III

SUPREME COURT
OF THE STATE OF WASHINGTON

In Re: Dependency of D.R. and A.R.,

State of Washington

v.

T.R.

FILED
SUPREME COURT
STATE OF WASHINGTON
2010 MAR 24 P 3:05
BY RICHARD H. GARDNER
CLERK

MEMORANDUM OF *AMICI CURIAE* IN SUPPORT OF
CHILDREN'S JOINT MOTION FOR DISCRETIONARY REVIEW

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I. INTRODUCTION

The Court of Appeals decision in *In re Dependency of D.R. and A.R.*, Nos. 27394-6-III & 27395-4-III (Dec. 28, 2009) (the “Court of Appeals Decision”) departs from existing case law to create a legal and practical impediment to children’s right of access to counsel. Over thirty other states provide children in dependency and termination proceedings this crucial right. However, the Court of Appeals Decision ensures this issue will likely never be heard in Washington. This Court should consider Washington’s critical due process right and provide children access to counsel.

II. IDENTITY AND INTEREST OF *AMICI*

National Center for Youth Law, First Star, National Association of Counsel for Children and Children’s Law Center of Los Angeles (collectively, “*Amici*”) file this Memorandum in Support of the Children’s Joint Motion for Discretionary Review pursuant to RAP 13.4(h). National Center for Youth Law is a non-profit organization that works to improve the lives of poor children nationwide by providing representation to minors in impact cases. First Star is a non-profit organization that supports abused and neglected children, including its Campaign for a Child’s Right to Counsel. The National Association of Counsel for Children is a non-profit child advocacy and professional membership

association dedicated to providing legal counsel for children and improving their lives through legal advocacy. The Children's Law Center of Los Angeles is a non-profit organization that receives appointments from the Los Angeles dependency court to serve as counsel for abused children. It has been providing children with representation for 20 years and serves a greater number of children than any such organization in the country.

III. ARGUMENT

A. **The Failure to Appoint Counsel for Children in Dependency and Termination Proceedings will be Repeated Often under the Court of Appeals Decision.**

The State conceded that no one advocated for D.R. and A.R.'s legal position. Mot. to Reverse and Remand, *In re Dependency of D.R. and A.R.*, No. 27394-6-III at 2-3 (July 1, 2009). Though D.R.'s mother requested legal representation for D.R., none was appointed. *See id.* Neither D.R.'s Guardian ad Litem nor her therapist appeared to have any understanding of the legal impact that termination would have on D.R., or of the legal arguments that might avoid any adverse impacts. *Id.* As even the State concedes, A.R.'s in-patient mental health treatment and designation and treatment as a sexually aggressive youth present legal issues that were never considered. *Id.*

Like D.R. and A.R. (collectively, the “Children”), many children in foster care deal with issues that implicate state and federal rights. Such rights remain un-enforced without access to counsel. For example, severe emotional disturbance is prevalent in 72 percent of children in foster care.¹ Like A.R., one in ten children placed in foster care in Washington are designated as sexually aggressive.² Moreover, the evidence shows that children who are subject to termination and dependency proceedings experience extensive, long-term problems with education, are often subject to detention, and are disproportionately involved with the juvenile justice system.³ These vulnerabilities warrant the appointment of legal counsel to advocate for children’s legal interests.

¹ Eric W. Trupin, et al., *Children on Child Protective Services Caseloads: Prevalence and Nature of Serious Emotional Disturbance*, 17 *Child Abuse & Neglect* at 348-49 (1993), attached hereto as Appendix A.

² 2007-2009 Braam Outcomes: Survey of Foster Parents and Caregivers in Washington State, Tech. Report 09-045 at 56 (Sept. 2009), available at http://www.dshs.wa.gov/pdf/ca/BRM3_2007-2009Comparisons.pdf.

³ Mason Burley & Mina Halpern, *Educational Attainment of Foster Youth: Achievement and Graduation Outcomes for Children in State Care*, Wash. State Inst. for Public Policy, Doc. No. 01-11-3901 at 12-25 (Nov. 2001), available at <http://www.wsipp.wa.gov/rptfiles/FCEDReport.pdf>; Madelyn Freundlich & Leslee Morris, *Youth Involvement in the Child Welfare and Juvenile Justice Systems: A Case of Double Jeopardy?* at 7-12, 24, 27-28, 51-52 (2004) (youth in foster care more likely to be detained; setting forth studies showing foster youth more likely to become involved with juvenile justice system).

Under the Court of Appeals Decision, however, the pattern of denying foster children the right to counsel will repeat and evade review continually. The current statutory scheme does not designate anyone to advocate for the child's right to counsel. The issue continues to evade review in the courts because few parents or guardians have the tenacity or even the awareness of the potential legal issues to advance their children's right to counsel. Alternatively, in many abuse and neglect proceedings, the interests of parents and children conflict and parents are unlikely to advocate for legal counsel for their child. When parents do fight for their children's rights, as T.R. did in this case, the Court of Appeals Decision ensures that the State, and not the courts, will determine whether the issue is ever decided. Review by this Court is critical to breaking that cycle and ensuring uniform enforcement of each child's right to counsel.

B. Over Thirty States Appoint Counsel for All Children in Termination and Dependency Proceedings.

Although Washington courts value the right to counsel, Washington is among the few states that deny the right to children in termination and dependency proceedings.

This Court recognized that the right to counsel is paramount where an individual is faced with the deprivation of liberty. *In re Myrick's Welfare*, 85 Wn.2d 252, 255, 533 P.2d 841 (1975). Dependency and termination proceedings concern such fundamental rights for children.

E.g., id. (holding parent in dependency proceeding entitled to counsel because familial relations involve fundamental rights); *In re Luscier's Welfare*, 84 Wn.2d 135, 139, 524 P.2d 906 (1974) (holding constitution requires appointment of counsel for parent in termination proceedings because familial relations involve fundamental rights); *Smith v. Fontana*, 818 F.2d 1411, 1418 (9th Cir. 1987) (“constitutional interest in familial companionship and society logically extends to protect children from unwarranted state interference with their relationships with their parents. . . [There is] no reason to accord less constitutional value to the child-parent relationship than . . . to the parent-child relationship.”), *overruled on other grounds by Hodgers-Durgin v. de la Vina*, 199 F.3d 1037 (9th Cir. 1999).

Washington state, however, ranks in the bottom third when it comes to securing legal representation for children in dependency and termination proceedings. First Star & Children’s Advocacy Institute, Second Edition: A Child’s Right to Counsel at 8-9, 126-28 (CAI 2009).⁴

⁴ Available at http://www.firststar.org/documents/Final_RTC_2nd_Edition.pdf. In the last two report cards, Washington has received “D” and “F” grades. *Id.* at 126; Whytni K. Ferederick & Deborah L. Sams, A Child’s Right to Counsel: First Star’s National Report Card on Legal Representation for Children at 108-09 (2007), available at <http://www.firststar.org/research/documents/FIRSTSTARReportCard07.pdf>. Excerpts of the report cards are attached hereto as Appendices B (2009) and C (2007).

Washington state compares poorly with the thirty-plus states that grant a universal right to counsel, the majority of which guarantee a client-directed relationship. *Id.* at 8. Across the country, courts are tackling the issue and recognizing the need to address the specific rights of vulnerable children in termination and dependency proceedings.⁵ The Court of Appeals Decision not only pushes Washington in the wrong direction, it allows the State to determine when (if ever) the issue will be reviewed.

C. The Effects of Not Appointing Counsel are Costly and Devastating.

More than thirty other states have found economical ways to provide counsel to all children in termination and dependency proceedings—because the cost of not appointing legal representation is even greater. Without counsel, children subject to dependency and termination proceedings are likely to be abused and neglected, or to

⁵ *Kenny A. v. Perdue*, No. 1 : 02-cv1686 (Dkt. No. 609) (N.D. Ga. May 19, 2009) (order requiring appointment of counsel for all children in dependency proceedings); *In re J.G.*, 652 S.E.2d 266 (N.C. Ct. App. 2007) (narrowing states' rights to determine the use of social security funds belonging to children in foster care); *D.G. v. Henry*, No. 4:08-cv-00074, Minute Order (Dkt. No. 270) (N.D. Okla. May 5, 2009) (approving class-action designation in lawsuit alleging mistreatment of children in state custody).

continue to be abused and neglected.⁶ Abused and neglected children experience a litany of adverse outcomes throughout their lives including poor physical health, poor emotional and mental health, social difficulties, cognitive dysfunction, high-risk behaviors and behavioral problems. Ching-Tung Wang & John Holton, Total Estimated Cost of Child Abuse and Neglect in the U.S. at 1 (Prevent Child Abuse America 2007).⁷ The aggression, juvenile delinquency, poor language development, eating disorders and other ills that plague these children will tax the State's treasury for custody and treatment in amounts that far outweigh the costs of legal counsel. Prevent Child Abuse America found that the estimated annual cost of child abuse and neglect is \$103.8 billion. *Id.* at 2, 4-5. The data demonstrates that Washington's children are not immune from these vulnerabilities. *See* Section III.A, *supra*.

⁶ *See* Andrew E. Zinn & Jack Slowriver, Evaluation of the Legal Aid Society of Palm Beach County's Foster Children's Project: Final Report at 1, 13-14 (Chapin Hall Center for Children at the Univ. of Chicago 2008) (children with counsel have greater exit rate from foster care); John Tarnai & Rose Krebill-Prather, 2008 Survey of Washington State Youth in Foster Care at 21 (Aug. 2008) (children in care more likely to be abused and neglected), available at <http://braampanel.org/YouthSurveyDataReport2008.pdf>.

⁷ Attached hereto at Appendix D and available at http://www.preventchildabuse.org/about_us/media_releases/pcaa_pew_economic_impact_study_final.pdf.

Conversely, a recent study in Palm Beach County, Florida analyzed the costs of implementing a program that required counsel for all children entering the foster care system. *Zinn & Slowriver, supra* note 6. Requiring representation for every child resulted in a net savings in the overall cost of care. *Id.* at 24. At the same time, children with legal representation were found to have better outcomes, including a “significantly higher rate of permanency.” *Id.* at 1, 13-14.

Washington cannot afford to continue to appoint legal counsel in only a select few proceedings. The Court of Appeals Decision places the State in control of any legal review by allowing it to concede and moot the issue. The consequence is financially costly for Washington and devastating to the health and well-being of children in the State.

III. CONCLUSION

Unless review is granted on the Court of Appeals Decision, these valuable rights will be impaired significantly. Washington will remain an outlier by continuing to deny counsel to children in dependency and termination proceedings. The economic and societal costs are severe.

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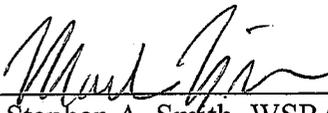
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Amici respectfully request that the Court grant the Children's Joint Motion
for Discretionary Review.

DATED this 15th day of March, 2010.

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APPENDICES

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In Re: Dependency of D.R. and A.R., State of Washington v. T.R.
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Appendix A Eric W. Trupin, et al., *Children on Child Protective Services Caseloads: Prevalence and Nature of Serious Emotional Disturbance*, 17 Child Abuse & Neglect (1993)

Appendix B Excerpts of First Star & Children's Advocacy Institute, Second Edition: A Child's Right to Counsel (CAI 2009)

Appendix C Excerpts of Whytni K. Ferederick & Deborah L. Sams, A Child's Right to Counsel: First Star's National Report Card on Legal Representation for Children (2007)

Appendix D Ching-Tung Wang & John Holton, Total Estimated Cost of Child Abuse and Neglect in the U.S. (Prevent Child Abuse America 2007)

APPENDIX A

CHILDREN ON CHILD PROTECTIVE SERVICE CASELOADS: PREVALENCE AND NATURE OF SERIOUS EMOTIONAL DISTURBANCE

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Abstract—A multivariate, criterion-referenced approach was used to assess prevalence of serious emotional disturbance among children on protective service case loads. Of 140 recipients of protective services, 72% were statistically indistinguishable from children in Washington State's most intensive mental health treatment programs. School problems, substance abuse, and antisocial behaviors were common in the sample, as were family histories of mental illness or substance abuse. Greatest service needs included family support groups, outpatient treatment, school-based treatment, and diagnostic services. These results underline the importance of structural changes to facilitate cross-system collaboration between mental health and protective services.

Key Words—Emotional disturbance, Mental health.

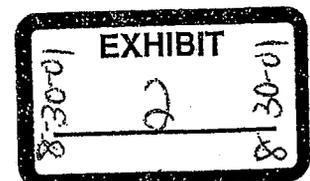
INTRODUCTION

NATIONALLY, 2.2 MILLION children were referred to child protective services (CPS) in 1986. This represents a 12% increase over 1985, and a 223% increase since 1976 (American Association for Protecting Children, 1988). Referrals have continued to increase steadily in the last 2 years. Although rates vary from state to state, allegations of abuse typically have been substantiated in approximately 40% of cases investigated, with 47% of investigated cases receiving some preventive or remedial services (American Association for Protecting Children, 1984). An estimated 270,000 children nationwide are in foster care. Three-quarters of these children are in substitute care settings because of maltreatment or neglect (Shor, 1988). Relatively little is known about the mental health status of these children, even though a substantial body of clinical and research literature documents relationships between abuse and emotional or behavioral disturbance.

The National Family Violence Study (Straus, Gelles, & Steinmetz, 1980) in the United States and a parallel study in Sweden (Gelles & Edfeldt, 1986) report that children were victims of severe violence, defined as being kicked, punched, beat up, threatened with a weapon, or assaulted with a weapon, at the annual rate of 3.6 and 4.1%, respectively, for the two countries. Large scale studies of sexual abuse report lifetime prevalence of 10 to 16% (Baker & Duncan, 1985; Finkelhor, 1987). Developmentally-oriented research indicates that victims of assault manifest disturbances that vary according to the child's age and the nature of the assault. Physically abused infants play less than comparison infants, are less focused, show less positive affect (Wasserman, Gardier, Allen, & Shilansky, 1987) and show patterns of

Received for publication October 10, 1990, final revision received April 22, 1992, accepted May 26, 1992.

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disorganized or anxious attachment (Cicchetti, 1987; Field, 1987). Young abused children evidence lags in play development (Howard, 1986) and higher numbers of behavioral problems (Wolfe & Mosk, 1983). Incest has been linked to depression, nightmares, bed wetting, clinging, and anxiety (Oates, 1987) as well as sexual acting out (Emslie & Rosenfeld, 1983). Neglect has been associated with emotional withdrawal and intellectual delay (Kent, 1976). Conversely, high prevalence of abuse has been found among adjudicated adolescents (Sandberg, 1986), drug abusing adolescents (Dembo et al., 1987), and psychiatrically hospitalized children (Emslie & Rosenfeld, 1983; Monane, Leichter, & Lewis, 1984).

The results from the preceding studies suggest that a substantial percentage of children receiving protective services may evidence emotional and behavioral disturbance. Limited empirical evidence exists to support this contention. A recent review of 1,029 consecutive CPS intakes in Washington State showed that behavioral problems were among the leading referral factors in 8% of cases. Ten percent of the intakes indicated that the child showed "visible emotional distress" at the time of referral (D. English, personal communication, October, 1987). In general, however, the prevalence of psychological disturbance in CPS case loads remains unclear despite the obvious risks to which these children have been exposed.

Since 1980, several general population surveys of childhood behavioral and emotional disturbance have been completed. They provide comparison data as well as a methodology for examining similar disturbance in children on CPS case loads. Brandenburg, Friedman, and Silver (1990) summarize the results of seven community surveys. They characterize disturbance along two dimensions, pervasiveness (defined by problems at both home and school) and chronicity (defined as the persistence of symptoms over a period of years). Point-prevalence figures based on behavior ratings from either teachers or parents range from 8 to 26%, with 5 of 7 studies reporting prevalence between 14 and 19%. When the criterion of pervasiveness is added, estimates drop by approximately 10%. Four of six studies reported point-prevalence of between 5.5 and 7.3%. Adding the criterion of chronicity, it is estimated that approximately 1% of children evidence disturbance that is both pervasive and chronic. The persistence of a disorder appears to be related to diagnosis, with attention deficit, conduct, and oppositional disorders showing greater chronicity than affective disorders.

The present study comprises a survey of children served by Child Protective Services in the State of Washington, with the specific intent of assessing mental health status. The study was completed as part of a larger community survey, the system analysis conducted through the Washington State Child and Adolescent Service System Program (CASSP; Low, Trupin, Forsyth-Stephens, & Cox, 1990). The CASSP system analysis was an empirical study of children in Washington State that generated estimates of the prevalence of serious emotional disturbance, as well as data relevant to children's service history, needs, and barriers to appropriate services. Public school children and children in various state-funded social service programs were surveyed independently. The present study reports data on children sampled through the Department of Child and Family Services who were receiving protective services at the time of the survey.

METHODOLOGY

Sample

The subjects were 191 randomly selected children currently receiving services from CPS. In order to receive these services the child must pass a sufficiency screen which requires that: (a) The agency has adequate information to locate the child; (b) a specific allegation has been made of abuse meeting legal definitions for sexual or physical abuse, abandonment or neglect;

or a specific risk factor places the child at risk of imminent harm; and (c) the alleged perpetrator is a caretaker or acting en loco parentis or the parent has been negligent in protecting the child from the perpetrator. Subjects were drawn from a randomly ordered listing of 1,640 children meeting these criteria. A three digit random number from a random numbers table was used to select the first case and then every *n*th case thereafter was selected from this listing to comprise the final sample.

Instruments and Respondents

The survey tool was an op-scan formatted questionnaire entitled "Child Mental Health Survey." The five sections of the instrument covered the surveyed child's background, mental health treatment history, current adjustment, exposure to environmental "risk factors," handicapping conditions, and mental health/social service needs. Respondents included DCFS caseworkers, other social workers, and facility counselors, dependent on who best knew the surveyed child. To provide a standard measure of current adjustment, the Achenbach Child Behavior Checklist (CBCL; Achenbach & Edelbrock, 1978) was embedded in the survey instrument. The CBCL consists of a list of 122 behavioral or symptomatic descriptors, and the respondent codes the extent to which each is characteristic of the child in question. The CBCL yields age- and sex-normed scores on specific clinical scales and on global disturbance scales. The child receives a *T*-score, with a score of 70 being at the 98th percentile for deviancy. This score is used to indicate the extent of disturbance for a given child.

As part of a larger study (Low et al., 1990), this instrument was piloted, revised, and subsequently administered to 4,990 children and adolescents in Washington state, including public school enrollees ($n = 1,592$), and children receiving a variety of mental health, and child and family services from the state Department of Social and Health Services (DSHS; $n = 3,398$). This earlier study describes the development of this instrument. Generally, the reliability of the survey was found to be quite good. Kappas between pairs of respondents rating subjects blindly were for the most part between .60 and .80. The coefficient alpha values for the CBCL scales were also good, with a median value of .84.

ANALYSIS AND RESULTS

Sample and Respondent Demographics

Children in the final sample of 191 ranged in age from 3 years to 18 years. The mean age was 9 years, 5 months and the median was 8 years, 10 months. Gender information was given for 83% of the cases, and indicated that 57% were female and 43% male. Children's ethnicity varied as follows: Caucasian—70%; Black—10%; Hispanic—6%; Native American—7%; and Asian—4%. Another 4% were described as "other" or as having a mixed racial background.

Using the Hollingshead two-factor index of socioeconomic status (Hollingshead, 1977), 127 of the children could be unambiguously classified as follows: Lower Class—54%, Working Class—40%, Middle Class—6%.

The survey respondents for this sample were state caseworkers (81%) or social workers (17%). With respect to sex, 73% were female and 27% male. Among these respondents, 52% had masters degrees and 47% had bachelors degrees. Respondents had known the child in question for an average of 14 months.

Prevalence of Serious Emotional Disturbance

An empirical, criterion-referenced approach was taken in classifying surveyed children as SED. The criterion group was defined as all children being served in state-funded psychiatric

Table 1. Indicators of SED

	CPS	Criterion Group
Childhood psychopathology correlates	4.5	7.5
SEM ^a	(0.2)	(0.4)
Chronicity	1.9 ^b	1.4
SEM	(0.0)	(0.1)
Service need	8.1	11.0
SEM	(0.3)	(0.6)
Internalizing behavior problems	53.4	69.3
SEM	(1.0)	(1.2)
Externalizing behavior problems	54.2	68.2
SEM	(1.2)	(1.5)

^a SEM = standard error of mean.

^b 1 = yes, 2 = no.

inpatient, residential, and hospitalization alternative programs (intensive day treatment with therapeutic foster care). These programs offer the most comprehensive and intensive mental health services available to children through the Washington state system. The Child Mental Health Survey was administered to the 169 children receiving these services. The larger study (Low et al., 1990) demonstrated that this group had the highest levels of serious emotional disturbance of all the subgroups surveyed and were an appropriate criterion group for assessing SED status. Using Hotelling's T^2 , that study found a multivariate composite of five variables that maximally distinguished this SED criterion group from other DSHS service recipients and from children enrolled in public schools. These variables were:

1. Correlates of Childhood Psychopathology: the number of positive responses to 13 correlates of childhood psychopathology;
2. Chronicity: duration of severe disturbance for one year or longer;
3. Service Need: the number of 32 possible services endorsed as "needed" or "currently received";
4. Internalizing Behavior Problem: Achenbach CBCL internalizing score; and
5. Externalizing Behavior Problem: Achenbach CBCL externalizing score.

Using this five-variable composite, an SED score was calculated for each child in the CPS sample. The means for each of these five variables are presented in Table 1 for both the CPS sample and the criterion group.

Using the SED group's centroid on the multivariate five-variable composite from the aforementioned study as a criterion, we next calculated the Mahalanobis Distance (D^2) between this criterion group centroid and the SED score for each child in the CPS sample using the formulae and rationale provided by Kshirsagar (1972, pp. 122-126). Utilizing this approach permitted an assessment of how many children in the CPS sample had SED scores which were statistically indistinguishable from the group centroid of the SED criterion group and thus could be classified as SED.

The D^2 scores of the CPS sample and the criterion group comprise two overlapping distributions. Moving the cutting point closer to the mean of the criterion group results in a more conservative discrimination rule, but also a higher alpha level. Moving the cutting score closer to the mean of the CPS sample results in a more liberal decision rule but a lower alpha level. In short, the location of the cutting score directly affects the number of false positives and false negatives. With alpha set at .10, a lower number of CPS children are indistinguishable from the criterion group and therefore are considered SED than when alpha is set at .05. For this study, the alpha was set at .10 to take a more conservative approach to false positives.

Multivariate SED scores were available for 135 of the 191 children in the sample, due to missing or incomplete data. Among these 135, however, 97 (72%) were classified as SED meaning they were statistically indistinguishable from the mental health criterion group. This is consistent with a prevalence of 70.7% SED for a broader sample of children receiving services from the Washington Department of Social and Health Services (Low et al., 1990).

Nature of Emotional Disturbance

A closer examination of the data provides descriptive information that helps to characterize the nature of emotional and behavioral disturbance among these children.

Childhood psychopathology correlates. Children being served by CPS had experienced a number of events that might be considered antecedents of childhood emotional/behavioral disturbance or indirect indicators of such disturbance. Psychiatric disturbance in parents or other family members was common (37%), and a positive family history of alcohol or drug dependence was noted for almost 70% of the sample. Not surprisingly, the vast majority (97%) of the sampled children experienced prior abuse or neglect. (Note that in Washington State children may receive protective services because they are at high risk of abuse apart from whether the child has suffered abuse previously.) The high frequency of placement in foster care (75%) or in the homes of extended family (26%) also attests to inadequacy and inconsistency in these children's home environments.

Maladaptive behaviors. In addition to scale scores that were used in the statistical analyses, individual item responses provide yet another indicator of disturbance in the sample. In the sample, 9% had been legally adjudicated or placed in youth diversion programs, 8% had been expelled, 14% had been suspended, and 37% had been identified as likely to be in need of special education services. Another 15% had run away from home for at least 24 hours, and 16% were identified as manifesting pervasive aggression, (e.g., suicidal or homicidal behaviors, fire setting, theft, vandalism, sexual abuse of others, etc.). Eight percent were identified as manifesting severe withdrawal (i.e., having no friends other than adults).

The presence of emerging antisocial and other maladaptive behaviors in many of the sampled children was confirmed by specific CBCL items. School problems were endorsed for 45% of children, with truancy noted specifically for 17%. Other conduct problems were distributed as follows: Run away—16%; theft—20%; drugs/alcohol use—21%. Since half of the children sampled were 8 years of age or younger, it is probable that rates of these antisocial behaviors are even higher among older children and adolescents served by CPS. These results provide further evidence of behavioral and emotional pathology and also suggest that this population may be at significant risk for contributing to or falling victim to antisocial activities associated with substance abuse.

Psychiatric classification. Psychopathology can be thought of as either a continuous dimension ranging from normality to extreme disturbance, or as a number of discrete categories. The CBCL Total Behavior Problem Score and specific clinical scale scores provide dimensional indices on which psychiatric classification might be based. Children in this sample had a mean Total Behavioral Problem *T*-score of 54.03 (SEM 1.18). Internalizing scores, reflective of psychic distress, anxiety, depression, and withdrawal averaged 53.41 (SEM .98); and externalizing scores, reflective of acting out behaviors averaged 54.16 (SEM 1.17).

With respect to categorical indices of disturbance, only 41 of the children or 21% had DSM-III Axis I or II diagnoses that were known to the respondents. Attention deficit disorder and specific developmental disorder, was the most frequently endorsed ($n = 6$), followed by

posttraumatic stress disorder and specific developmental disorder ($n = 5$ each). The remaining diagnoses were scattered across 11 different diagnostic categories. The dearth of psychiatric diagnoses for these children in spite of relatively high levels of disturbance may reflect lack of awareness that psychiatric diagnoses had been assigned, or it may simply reflect the absence of previous psychological assessment for these children. In either case, even less information is available about the nature of disturbance in CPS children than about the extent of the disturbance.

Responses to another survey question suggest that this lack of information may be due in part to the failure of professionals involved with these children to conceptually link high levels of behavior disturbance to emotional or psychological distress. When asked the age at which emotional problems had begun for the child in question, 37% of responses indicated that the question was not relevant (i.e., that there were no "emotional problems"). This is true in spite of the fact that by empirical criteria 72% could be classified as seriously emotionally disturbed.

Service History

The "age of onset" for emotional problems was known for 76 of the children. The age at first mental health contact was known in 84 of the cases. Comparison of these data indicate substantial delays in service receipt after the onset of emotional problems. Children were more likely to begin manifesting problems between ages 2 and 5, but were more likely to begin obtaining mental health services between ages 6 and 11. Because recognition and reporting of emotional problems lags behind onset, the actual disparity between problem onset and initiation of treatment may be larger than it appears.

Prior out-of-home placements are common among these children, both in the sample as a whole and among those children classified as SED. Most out-of-home services were categorized either as emergency placements, (i.e., in receiving homes or crisis residential facilities), or as foster care placements. For the entire CPS sample, 72% had emergency out-of-home placement and 69% had foster placements. For the SED subgroup of the CPS sample, 77% had emergency placements; 78% had foster placements. Group home placement and psychiatric hospitalizations were rare in both the full CPS sample and the CPS-SED subsample.

Needed Services

Current receipt of mental health services as well as unmet need were examined to reflect the status of children at the time of the study (See Table 2). Among the 191 children surveyed, case management and foster care were the services most frequently provided. Even traditional outpatient therapy, the most widely available form of mental health treatment, was obtained by these children less frequently than foster care. This is not surprising, given the mission of CPS. But it does underline the difficulty of providing comprehensive care through an agency that is mandated to protect children rather than to meet their mental health needs.

It appears that CPS does follow its mission and provides services relevant to protection at a high rate. Of the children meriting a crisis placement or foster placement, for example, most received the service. However, the same is not true for other mental health services. The area of greatest unmet need was for family support groups, followed by outpatient treatment, and school-based treatment, and diagnostic services.

Service Barriers

Respondents were asked to identify any of 24 barriers to a child receiving a needed service. A total of 734 barriers were endorsed. Nineteen percent of these barriers could be classified as child-focused, and reflected factors such as the child's antisocial behaviors, lack of coopera-

Table 2. Current Services and Service Needs (*N* = 191)

Service	Received	Needed
Psychiatric evaluation	02%	12%
Eval. for psychotropic medication	01%	02%
Psychological testing	04%	15%
Case management	75%	07%
Outpatient mental health treatment	35%	24%
Outpatient alcohol/drug treatment	01%	08%
Mental health day treatment	05%	05%
Therapeutic preschool or daycare	13%	06%
School-based mental health services	12%	19%
Intensive in-home services	04%	08%
Family reconciliation services	09%	09%
Family support group	21%	30%
Crisis residential/receiving home	07%	02%
Foster home placement	38%	06%
Group home placement	01%	03%
Psychiatric residential treatment	00%	01%
Psychiatric hospitalization	00%	01%
Inpatient alcohol/drug treatment	00%	03%

tion, and handicapping conditions. Only 21% of barriers reflected system difficulties such as insufficient funding, lack of capacity, nonexistence of appropriate service, or lack of cooperation among providers. Finally, 58% of barriers were family-focused, including, for example, misunderstanding of a child's needs, lack of compliance with recommendations, inability to afford services, and frequent moves. Across all three barrier categories, the modal barrier was "family's lack of cooperation" (endorsed 145 times). This was followed by "family's misunderstanding of the child's needs" (endorsed 77 times), and "family overwhelmed" (endorsed 78 times). From the perspective of service providers, factors pertaining to the family's motivation appeared to be the primary barrier preventing children from receiving needed mental health services.

DISCUSSION

Several limitations of the current study must be kept in mind while considering implications of the research findings. Limited information was obtained regarding the abuse histories of the children, making it impossible to assess severity of abuse or to differentiate subtypes such as neglect, physical abuse, and sexual abuse. The population is defined only in terms of the receipt of services through CPS. Second, no psychiatric interview was conducted to verify symptom or diagnostic information obtained from respondents. Information was not available from multiple settings or multiple respondents, limiting the ability to assess pervasiveness of dysfunction. Future research will need to address these limitations in order to provide a more precise clinical profile of children served by child protective services and to identify subgroups within this population. A limitation of the contrasted groups methodology in this case is that the criterion group was comprised of children who had been in intensive treatment programs for various lengths of time. The impact of treatment itself would presumably modulate their symptom profiles, thus possibly blurring some distinctions between criterion and other populations. The inclusion of history information reduces the impact of this on the multivariate composite, and the greatest impact would be on Achenbach scores.

In spite of these limitations, the present results have system and policy implications. The cognitive and emotional sequelae of abuse are increasingly acknowledged as contributing to

serious emotional disturbances. Hart and Brassard (1987), asserted that psychological maltreatment is inherent in all maltreatment and that the primary enduring effects of maltreatment are psychological. Clinical research supports this contention. The damaged attachment that results from abuse (Egeland & Shoufe, 1981; Schneider-Rosen & Cicchetti, 1984) has been linked to socio-emotional problems throughout childhood (e.g., Sroufe, 1983). In addition, a high correspondence exists between severity of abuse and extent of pathology in some adult disorders, for example borderline personality disorder (Herman, Perry, & Van der Kolk, 1989). Our finding that 72% of the CPS sample in our study were indistinguishable from the criterion group served in intensive psychiatric programs is consonant with clinical research and the observations of child mental health and welfare specialists. These professionals consistently observe that their caseloads contain a preponderance of children at risk for psychopathology because of family dependency, poverty, substance abuse, and inadequate social support systems (Shor, 1988). In such cases, abuse has an additive effect in predisposing children emotionally and socially to be "caretaking casualties" (Sameroff & Chandler, 1975).

It should be noted that the criterion used for defining SED status in this study was a statistical one. Seventy-two percent of the CPS was statistically indistinguishable from the criterion SED group on the five-variable multivariate composite score. This is a significant degree of overlap, but it should be remembered that the groups may differ on other variables or may present clinically in ways not reflected by the multivariate composite. Adopting a more conservative cutting score (setting alpha at .10 rather .05) to some extent mitigates this concern given the face validity of the composite, but leaves the question of other possible differences between the two groups.

The public policy implications of the present results challenge the current role of child welfare programs and their delivery of mental health services. Current service levels fail even to adequately assess and document the mental health needs of abused children. Kaplan and Zitlin (1983a) found that few of the CPS casework supervisors they surveyed regularly involved a psychologist or psychiatrist in assessment and disposition planning. Fifty-eight percent referred less than one-fourth of abused children for psychiatric evaluations. Likewise, 64% referred less than one-fourth for psychological assessment. A similarly low rate of mental health referral of abused children by hospitals has been documented (Kaplan & Zitlin, 1983b). Although 66% of 61 hospitals surveyed had child abuse teams, only 48% of these teams had a psychologist as a member, and 15% had a psychiatrist as a member. Only 17% of hospitals referred the majority of abused/neglected children for psychiatric evaluation, and 6% referred the majority for psychological assessment. In the present study, diagnostic services (encompassing both psychiatric evaluation and psychological assessment) was among the top three unmet service needs identified by casework professionals.

Given the failure to consistently assess psychological status and needs, it is not surprising that the current pattern of services offered fails to adequately address psychopathology in this population. The primary modes of intervention utilized by Child Protective Services, nationally, as well as in Washington, are foster placements and traditional child welfare case management. Foster care is typically provided by families or individuals with very limited training in the skills required to manage this population of children effectively.

When foster care becomes a sole treatment resource, the chaotic and disorganized early family environment of the child may be replicated in a series of unsuccessful foster placements (Sameroff & Chandler, 1975). Multiple foster placements become common as the children disrupt ill-prepared and relatively unsupported foster families who soon request relief from the behavior these children manifest. The cycle of multiple placement contributes to an increase in overall behavior pathology and school difficulties and fundamentally undermines attempts to provide a consistent environment wherein attachment to caregivers can be nurtured. Even though reunification with biological parents is the stated goal of most place-

ments, neither the child, nor the biological parent, nor the foster parent has access to services which might facilitate this outcome.

In addition to the relative ineffectiveness of the child welfare system in acknowledging, assessing, documenting and prioritizing the mental health needs of abused children, other system problems have prevented the mental health needs of abused children from being met:

Casework overload. Child Protective service workers typically carry case loads of 36 children with six to eight new referrals per month. Interim standards put forth by the American Association for Protecting Children (Winter, 1988) recommend a maximum of three new investigations per month and a overall case load of 17 to maintain quality case investigation and management. Intensive case management and procurement of multiple services for children is all but impossible when case loads are maintained at the current level. It is not surprising under these circumstances that the turnover of caseworkers is exceedingly high and that child protective agencies nationally have seen a significant reduction in recruitment and retention of trained social workers. The turnover of caseworkers further adds to discontinuity in planning for these children and contributes to the ambivalence or reluctance that the families of seriously disturbed children exhibit toward accessing services.

Paucity of services. Even within mental health systems, children remain an underserved population (Knitzer, 1982; Saxe, Cross, Silverman, & Batchelor, 1987). The more acute or chronic needs of mentally ill adults typically take priority. Children often need to demonstrate extreme forms of psychopathology before they qualify for services, and they may fail to meet criteria for state-funded treatment when these are predicated on adult models for chronicity or severity. Even when caseworkers desire mental health intervention they often are forced to rely on limited and less focused resources for providing care. In the present study, "inadequacies in the service system" accounted for approximately 20% of all identified service barriers.

Inflexible organizational boundaries. Currently, child welfare caseworkers can access mental health services for abused children only by crossing formidable organizational boundaries that: (a) block routine transfer of information regarding service availability, (b) limit communication about individual children, and (c) constrain the development of comprehensive child-centered service plans. Archaic funding structures make the procurement of individual mental health services from external contractors difficult, and at the organizational level, block the development of collaborative ventures. The provision of a narrow range of services thus becomes institutionalized.

Although the vast majority of seriously emotionally disturbed children surveyed in this study were reported as showing onset of problems between the ages of 2 and 5, these children did not actually receive services until much later, if they received such services at all. Delays in treatment at this critical developmental phase exacerbate these children's disorders and increase the likelihood that these disorders will become more chronic and more refractory to later intervention. The current child welfare system is designed for a population with significantly less psychopathology and fails to meet these children's mental health needs. The "protective" interventions employed by child protective services agencies on behalf of abused children only begin to address the extent of psychopathology, which we have found in the current study to be of epidemic proportions, among these children.

A knowledge base has developed over the past 20 years on effective programmatic interventions with abused children (Tuma, 1989). Successful programs have regularly crossed "traditional, professional, and bureaucratic boundaries" (Shor, 1988) in the delivery of mental health services within a child welfare context. That is, program caseworkers and allied professionals exercise maximum discretion in the pursuit of individual children's service needs.

These programs have provided health, as well as social and mental health services. Most child protective service systems currently offer low intensity case management and foster care rather than a comprehensive spectrum of services built on the insights derived from child development, family systems, and service systems research. Table 2 shows that case management and foster home placements are the most commonly prescribed interventions for these children although they are perceived as needed in a relatively small proportion of cases. As indicated in this table, other needed services are often not received. The results of this study demonstrate the need for a comprehensive array of mental health and social services for a large percentage of children on child protective service caseloads.

These findings are congruent with the recent Federal initiative to promote the integration of service planning and delivery for seriously disturbed children under a single "point of authority." The Child and Adolescent Service System Program (CASSP) has begun to provide the support and impetus to states for planning and implementing a continuum of service for seriously disturbed children (Friedman, 1986), in whatever organizational or bureaucratic venues they may be found. The reduction of boundaries between child protective and mental health services is imperative, given recent findings that children in many youth serving systems including CPS are, highly vulnerable to various forms of psychiatric morbidity, and are thus in need of multifaceted, multi-lateral intervention.

Acknowledgement—The authors express appreciation to Bill Jones for assistance with data analysis.

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Résumé—Cette étude portait sur les enfants qui sont desservis par les agences de protection de l'enfance. Elle avait pour but de déterminer le taux d'inadaptation psychologique chez ces enfants. Parmi 170 cas, 72 p.c. ressemblaient invariablement aux enfants qui sont suivis de façon intensive dans des services de santé mentale. On décèle des problèmes à l'école, la toxicomanie, le comportement antisocial, et des problèmes de santé mentale et de toxicomanie dans les familles de ces enfants. Les services les plus en demande sont les groupes de support à la famille, les services de traitement à l'externe, le traitement en milieu scolaire, et les services diagnostiques. Les résultats de l'étude soulignent l'importance des changements structurels qui assureront une collaboration soutenue entre les services de santé et ceux de la protection de l'enfance.

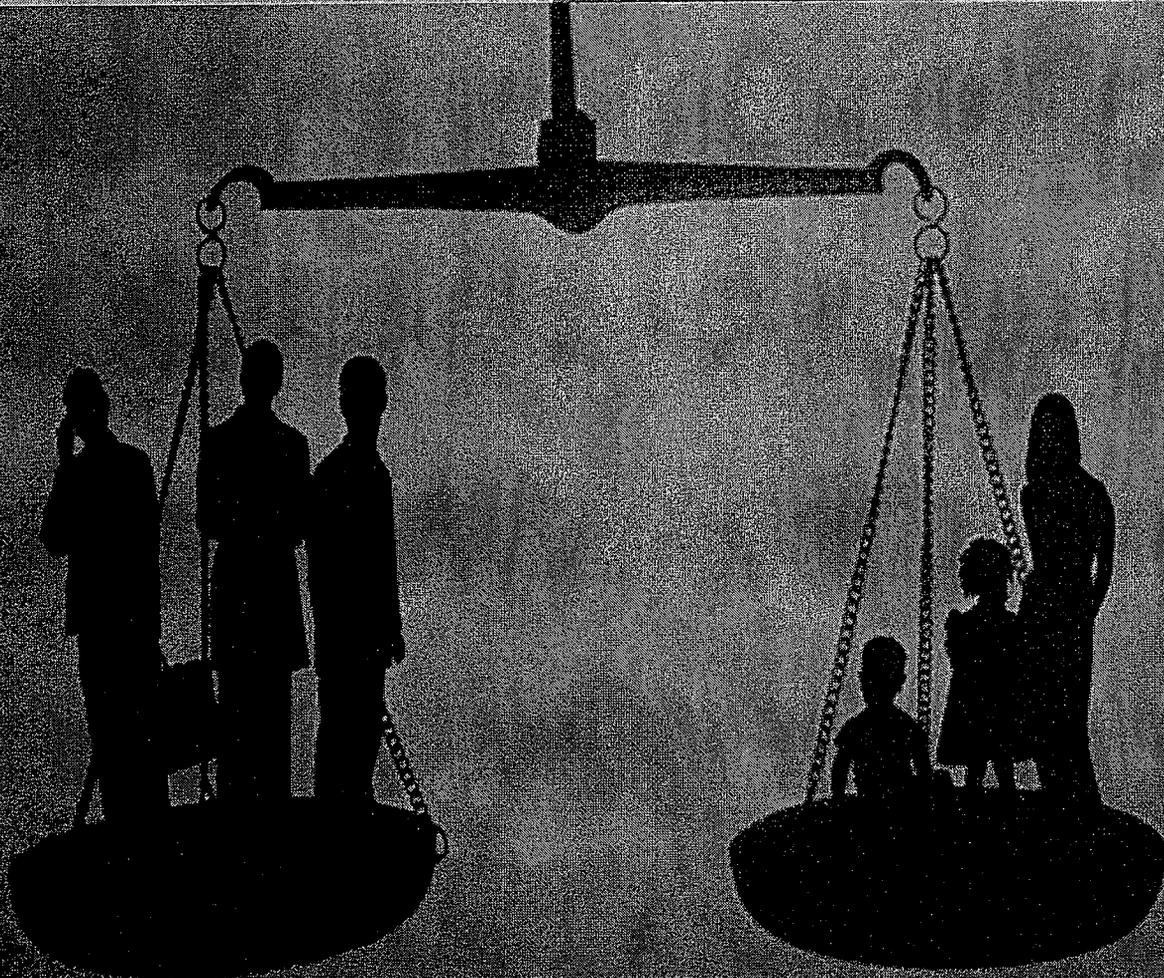
Resumen—Para evaluar la prevalencia de perturbaciones emocionales serias entre niños del servicio de protección, se utilizó un enfoque de criterios multivariado. De 140 recipientes de los servicios de protección, 72 por ciento no diferían estadísticamente de niños en los programas más intensos de salud mental en el estado de Washington. Problemas escolares, abuso de sustancias y conductas antisociales, eran comunes en esta muestra; como también lo eran las historias familiares de enfermedad mental o de abuso de sustancias. Las mayores necesidades del servicio incluían grupos de apoyo familiar, tratamiento ambulatorio, tratamiento con base en la escuela y servicio de diagnóstico. Estos resultados destacan la importancia de cambios estructurales para facilitar la colaboración entre los sistemas de salud mental y los de protección.

APPENDIX B

Second Edition

A CHILD'S RIGHT TO COUNSEL

**A NATIONAL REPORT CARD ON
LEGAL REPRESENTATION FOR
ABUSED & NEGLECTED CHILDREN**



Acknowledgments

First Star and CAI are extremely grateful to the many law interns and volunteers who contributed to the research and analysis contained in this report. Special thanks to Katie Ashley; Jessica Breslin; Jamie Cohn; Shireen Husain; Meredith Kimmel; Michael Lee; Jessica Liu; Alison Lobban; Melanie McLean; Briana Monahan; Natalie Nelson; Aaron Stoessel; Elizabeth Westbrook, and other report reviewers. First Star and CAI would also like to thank the many state officials and advocates who responded to our requests for feedback and information on their state laws and practices relevant to the legal representation of abused and neglected children. These individuals are listed in Appendix B.

About the Authors

First Star is a national non-profit organization working to improve the lives of America's abused and neglected children by strengthening their rights, illuminating systemic failures, and igniting reform to correct those failures. We pursue our mission through research, public engagement, policy advocacy, and litigation. First Star works to help achieve a future in which America's abused and neglected children have won their right to be heard and protected within the systems legally entrusted with their care, and in which those systems are fully resourced, transparent and accountable to the public.

First Star's Co-Founder and President, Peter Samuelson, is a motion picture executive who founded the Starlight Children's Foundation in 1982 and the Starbright Foundation in 1990. Sherry A. Quirk, Esq., Co-Founder and Vice Chair of First Star, a partner of Schiff Hardin, LLP, is past president and founder of One Voice and the National Coalition of Abuse Awareness. Amy Harfeld, Executive Director of First Star, has over 15 years of experience in child advocacy as a Teach For America corps member, human rights worker, and litigator.

First Star is proud to be a pro-bono client of Schiff Hardin, LLP.

The **Children's Advocacy Institute (CAI)** was founded in 1989 as part of the Center for Public Interest Law at the University of San Diego (USD) School of Law. CAI's mission is to improve the health, safety, development, and well-being of children. CAI advocates in the legislature to make the law, in the courts to interpret the law, before administrative agencies to implement the law, and before the public to provide public education to Californians on the status of children.

CAI strives to educate policymakers about the needs of children—about their needs for economic security, adequate nutrition, health care, education, quality child care, and protection from abuse, neglect, and injury. CAI's goal is to ensure that children's interests are represented effectively whenever and wherever government makes policy and budget decisions.

Robert C. Fellmeth, J.D., CAI's Executive Director, is the Price Professor of Public Interest Law at the USD School of Law and founder of both CAI and the Center for Public Interest Law. Professor Fellmeth has over 30 years of experience as a public interest law litigator, teacher, and scholar.

In addition to the law interns noted above, the primary authors of this report are Amy Harfeld of First Star and Christina Riehl and Elisa Weichel of the Children's Advocacy Institute.

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4. To what extent are specialized education and/or training requirements for the child's counsel required by state law? Is such education and/or training required to include multidisciplinary elements? (Maximum Points: 10)
 5. Does state law expressly give the child the legal status of a party with all rights appurtenant thereto? If not, does state law expressly give the child some of the rights of a party? (Maximum Points: 10)
 6. Do the Rules of Professional Conduct (or the state's equivalent thereto) regarding immunity from liability and confidentiality apply to attorneys representing children in dependency proceedings? (Maximum Points: 10)
- Extra Credit:** Does state law address caseload standards for children's counsel in dependency proceedings? (Maximum Extra Credit Points: 5)

Summary of Report Card Findings

The Second Edition of *A Child's Right to Counsel* demonstrates that many states have made laudable progress in their laws pertaining to the right to counsel for abused and neglected children in the last few years. Some states have excellent new laws on the books, and First Star and CAI commend the hard work of all the policymakers and advocates who led these reform efforts. Some states made great strides in moving new laws forward in this arena, but were faced with overburdened legislatures and a dismal financial climate that temporarily thwarted their efforts. We encourage them to continue their fight and hope that this report assists them in their advocacy.

We found that some states had excellent practices in providing counsel, but their practices were not codified in state law. First Star and CAI firmly believe that the only way to ensure consistent, enforceable, and accountable legal representation for abused and neglected children is to enact state law to that effect. We encourage states to incorporate their good work and established practice into law.

Unfortunately, we also found several examples of the opposite—states with strong right to counsel laws that are not followed in practice. We urge stakeholders in those states to use all advocacy and legal remedies available to enforce the law and ensure that abused and neglected children receive the representation to which they are legally entitled.

Statistical Highlights of the Second Edition

➤	11	States earned an A or A+
➤	11	States earned a B
➤	14	States earned a C
➤	8	States earned a D
➤	7	States earned an F
✓	63% of states mandate the appointment of an attorney for the child	
✓	51% of states mandate that the child's attorney, when appointed, serve in a client-directed capacity for the child	
✓	33% of states adopted new legislation in this arena since the First Edition of <i>A Child's Right to Counsel</i> in 2007	

The following 17 states (representing 33% of the jurisdictions studied) improved their state laws governing a child's right to counsel in dependency proceedings since the First Edition of *A Child's Right to Counsel*.

Alabama	Ohio
Arkansas	Oklahoma
California	Oregon
Connecticut	Pennsylvania
Iowa	Rhode Island
Louisiana	South Carolina
Massachusetts	Vermont
New Hampshire	Wyoming
New York	

First Star and the Children's Advocacy Institute applaud the two states that scored 100 or above, meriting a grade of A+: Massachusetts and Connecticut. May their laws in this arena serve as a beacon to their neighbors and states around the country looking for examples to follow.

Over 40% of the 51 jurisdictions surveyed earned a grade of A or B. We are proud to be able to award such high grades to states who recognize the importance of this issue and have taken the necessary steps to provide their maltreated children with effective legal representation.

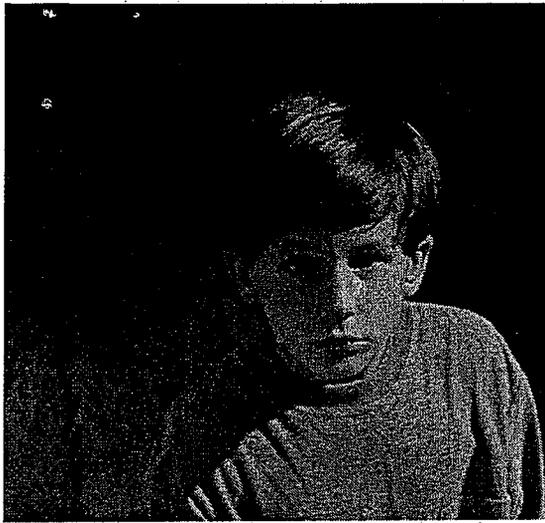
Approximately 30% of the 51 jurisdictions surveyed scored a D or an F. These states have a long way to go toward enacting laws that ensure children of the right to appropriate legal representation in dependency proceedings.

Conclusion

First Star and the Children's Advocacy Institute urge that federal and state law require all abused and neglected children to receive quality client-directed representation in dependency proceedings and eventually in all court proceedings in which they have important legal interests at stake. Tremendous progress has been made in the last few years in the fight to achieve this vision. It is our aim to build on that momentum and show all states and the federal government that it is possible and advantageous for all to adopt laws that protect abused and neglected children, give them a voice, and give them a greater chance to emerge from a very traumatic experience whole and strong.

We hope this report will serve as a useful tool in increasing public awareness of this issue and give advocates and policymakers information that can be used to advance state and federal legislative reform. It should serve as a rallying cry for advocates and lawmakers in poorly performing states, and as a source of pride for states that have enacted strong laws in this arena.

The suffering of abused and neglected children does not vary depending on what state they call home. Their ability to have their voice rightfully heard and considered as their futures are determined should also not depend on something so arbitrary as the two letter abbreviation at the end of their address.



Washington

Score: 61

Grade: D

1. Does state law mandate that attorneys be appointed for children in dependency proceedings?

Points: 15 out of 40

“The court shall appoint a guardian ad litem for a child who is the subject of an action under this chapter, unless a court for good cause finds the appointment unnecessary. The requirement of a guardian ad litem may be deemed satisfied if the child is represented by independent counsel in the proceedings” (Wash. Rev. Code Ann. § 13.34.100(1)). “Guardian ad litem” means a person, appointed by the court to represent the best interests of a child in a proceeding under this chapter” (Wash. Rev. Code Ann. § 13.34.030). “The term guardian ad litem shall not include an attorney appointed to represent a party” (Wash. Super. Ct. GALR, Rule 1(b)(2)).

“If the child requests legal counsel and is age twelve or older, or if the guardian ad litem or the court determines that the child needs to be independently represented by counsel, the court may appoint an attorney to represent the child’s position” (Wash. Rev. Code Ann. § 13.34.100(6)).

“Upon request of a party or on the court’s own initiative, the court shall appoint a lawyer for a juvenile who has no guardian ad litem and who is financially unable to obtain a lawyer without causing substantial hardship to himself or herself or the juvenile’s family....If the court has appointed a guardian ad litem for the juvenile, the court may, but need not, appoint a lawyer for the juvenile” (Wash. JUCR 9.2(c)(1)).

Basis for deduction: Under Washington law, the appointment of an attorney for a child in dependency proceedings is discretionary in some circumstances (e.g., if the child has a GAL) and conditional in others (e.g., the child has no GAL and a party has requested appointment of counsel or the court decides to appoint counsel).

2. When an attorney is appointed for a child in dependency proceedings, does state law define the duration of the appointment?

Points: 5 out of 10

Basis for deduction: In those cases in which an attorney has been appointed for a child in dependency court proceedings, Washington law does not expressly ensure attorney representation for children on appeal.

3. When an attorney is appointed for a child in dependency proceedings, does state law require the attorney to advocate for the expressed wishes of the child in a client-directed manner?

Points: 20 out of 20

When an attorney is appointed for a child in dependency proceedings, the role of the attorney is “to represent the child’s position” (Wash. Rev. Code Ann. § 13.34.100(6)).

4. To what extent are specialized education and/or training requirements for the child's counsel required by state law? Is such education and/or training required to include multidisciplinary elements?

Points: 6 out of 10

Any individual serving as a guardian ad litem must "comply with training requirements established under § 2.56.030 prior to appointment" (Wash. Rev. Code Ann. § 13.34.102).

Basis for deduction: Although Washington law requires specialized training for GALs, it does not expressly require specialized education and/or training for attorneys appointed as legal counsel for children in dependency proceedings.

5. Does state law expressly give the child the legal status of a party with all rights appurtenant thereto? If not, does state law expressly give the child some of the rights of a party?

Points: 5 out of 10

Washington law expressly provides some children in dependency proceedings with at least one right (the right to service of summons "if the child is twelve or more years of age" (Wash. Rev. Code Ann. § 13.34.070)).

Basis for deduction: Washington law does not expressly provide party status to children in dependency proceedings.

6. Do the Rules of Professional Conduct (or the state's equivalent thereto) pertaining to liability and confidentiality apply to attorneys representing children in dependency proceedings?

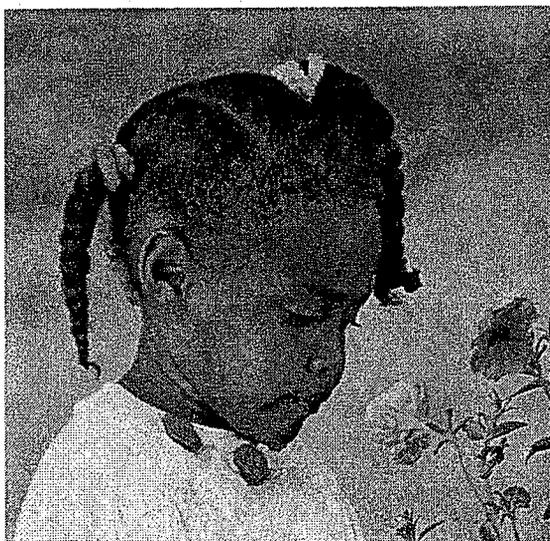
Points: 10 out of 10

"When a client's capacity to make adequately considered decisions in connection with a representation is diminished, whether because of minority, mental impairment or for some other reason, the lawyer shall, as far as reasonably possible, maintain a normal client-lawyer relationship with the client" (Wash. RPC 1.14(a)).

Extra Credit: Does state law address caseload standards for children's counsel in dependency proceedings?

Points: 0 extra credit points

Washington law does not address caseload standards for attorneys representing children in dependency proceedings.



SIDEBAR NOTES:

- ★ A bill introduced in the Washington Legislature in January 2009 would have recognized that few children in the state are given attorneys during dependency proceedings and their health, safety, and welfare are put at risk. H.B. 1183, and its companion bill S.B. 5609, would have required the court, whether or not requested by the child, to consider appointing an attorney at the first regularly scheduled hearing after (1) the child's 12th birthday, (2) the date the dependency petition is filed for a child age 12 or older, or (3) the date the bill takes effect, for unrepresented children who are already age 12 or older. If the court does not appoint an attorney, it must state its reasons on the record, tell the parties and the child, if present, of their right to request an attorney for the child in the future, and direct the caseworker or a party to notify any absent party of that right. In addition, the measure would have required the court to consider whether to appoint an attorney for the child at all subsequent hearings until an attorney is appointed or until the dependency is dismissed. Although these measures did not pass out of committee during 2009, Washington advocates will introduce a new right to counsel bill in the next session.
- ★ Similarly, a bill was introduced in the 2008 Washington legislative session addressing legal representation for children in dependency proceedings who are age twelve or older. H.B. 3048, and its companion bill S.B. 6896, would have established a Dependent Youth Representation Pilot Program to ensure that in the selected counties all children ages twelve and over who are in dependency proceedings have legal representation, and would have requested that University of Washington School of Law, Children and Youth Advocacy Clinic administer the Pilot Program, measure its effectiveness and issue preliminary and final reports to the legislature.
- ★ Although attorneys appointed for children pursuant to Wash. Rev. Code Ann. § 13.34.100(6) are required "to represent the child's position," it is unclear whether that same role applies to attorneys appointed for children pursuant to Wash. JUCR 9.2(c)(1), which does not expressly state whether the attorney is to advocate for the child in a client-directed manner or advocate for the child's best interests.
- ★ Although the appointment of legal counsel for children is discretionary and/or conditional under Washington state law, it is common practice in King County (where Seattle is located) for children age 12 and older to be automatically appointed an attorney in dependency and termination proceedings. Also, in Benton-Franklin County, the general practice is to appoint attorneys for children age 9 and older, and appoint CASAs for children age 8 and younger.

APPENDIX C

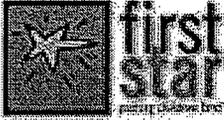
A CHILD'S RIGHT TO COUNSEL

First Star's National Report Card on Legal Representation for Children

Whytni Kernodle Frederick Esq., Program Director, Legal Projects, First Star
Principal Investigator and Research Analyst

Deborah L. Sams, Chief Executive Officer, First Star
Project Director

With a foreword by Peter Samuelson, *Founder and President of First Star*



First Star was founded in 1999 as a national 501(c)(3) public charity dedicated to improving life for child victims of abuse and neglect. First Star's Founder and President, Peter Samuelson, also founded the Starlight Children's Foundation in 1982 and the Starbright Foundation in 1990.

We believe that when society fails to prevent child maltreatment, our nation must provide abused and neglected children with quality and compassionate care.

We believe that abused and neglected children have the right to:

- Safe, permanent and nurturing homes.
- Representation by qualified legal counsel.
- Protection by open and accountable systems.
- Services that address their educational, medical and mental health needs.

We believe that the systems intended to protect, treat and ensure permanency for abused and neglected children should be provided with adequate resources.

We believe that the child welfare professionals who protect, treat and represent abused and neglected children should be well-trained and fairly compensated.

We believe that child abuse and neglect is not a partisan issue.

In 2006, First Star conducted an extensive analysis of child representation laws in all 50 United States and the District of Columbia.

First Star obtained the data on which the states' grades are based through leveraging its own existing compilation of statutes and rules with data received through a commercial legal database as well as state legislative websites. In addition, a questionnaire devised to gather information directly from the states was sent to practitioners in every state. To the best of our knowledge, the laws that were analyzed for this report were current as of December 31, 2006.

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Washington

Summary and Analysis

A GAL IS REQUIRED IN ALL ABUSE AND NEGLECT PROCEEDINGS. The GAL does not need to be an attorney. If a child requests legal counsel and is age twelve or older, or if the GAL or the court determines that the child needs to be independently represented by counsel, the court may appoint an attorney to represent the child's position. The GAL requirement is fulfilled with the appointment of independent counsel. There is no statutory provision requiring the GAL to express the child's views to the court.

Grading Analysis

Criteria	How Washington Fared
Counsel Mandatory 15 points out of a possible 40 points	Washington provides only for the appointment of a guardian ad litem who may or may not be an attorney. The court may appoint legal counsel if the child is twelve years of age or older and requests one or if the GAL or court determines that the child needs to be independently represented.
Client Directed Counsel Mandatory 6 points out of a possible 20 points	The GAL must represent the "best interests" of the child. There is no provision requiring the GAL to inform the court of the child's views. Where independent counsel is appointed, counsel performs in the traditional attorney role.
Professional Considerations 0 points out of a possible 10 points	Washington law neither provides guidance on training for children's counsel nor authorizes multidisciplinary interaction between professionals.
Presence at Proceedings 0 points out of a possible 10 points	Washington law does not specifically indicate that a child is a party in child abuse and neglect cases. A child has no statutory right to be present at any proceeding in Washington. Washington law does not provide that a child be entitled to notice.
Right to Continuity of Counsel 0 points out of a possible 10 points	There are no expressed statutory provisions guaranteeing the right to counsel at any stage of the proceedings.
Professional Responsibility 10 points out of a possible 10 points	Washington has a general provision binding counsel to its ethical rules. Washington also holds an attorney responsible for maintaining client confidences and maintains a provision concerning clients with diminished capacity. No statutory provision granting immunity from malpractice exists for any attorney in Washington.

GRADE

F

SCORE

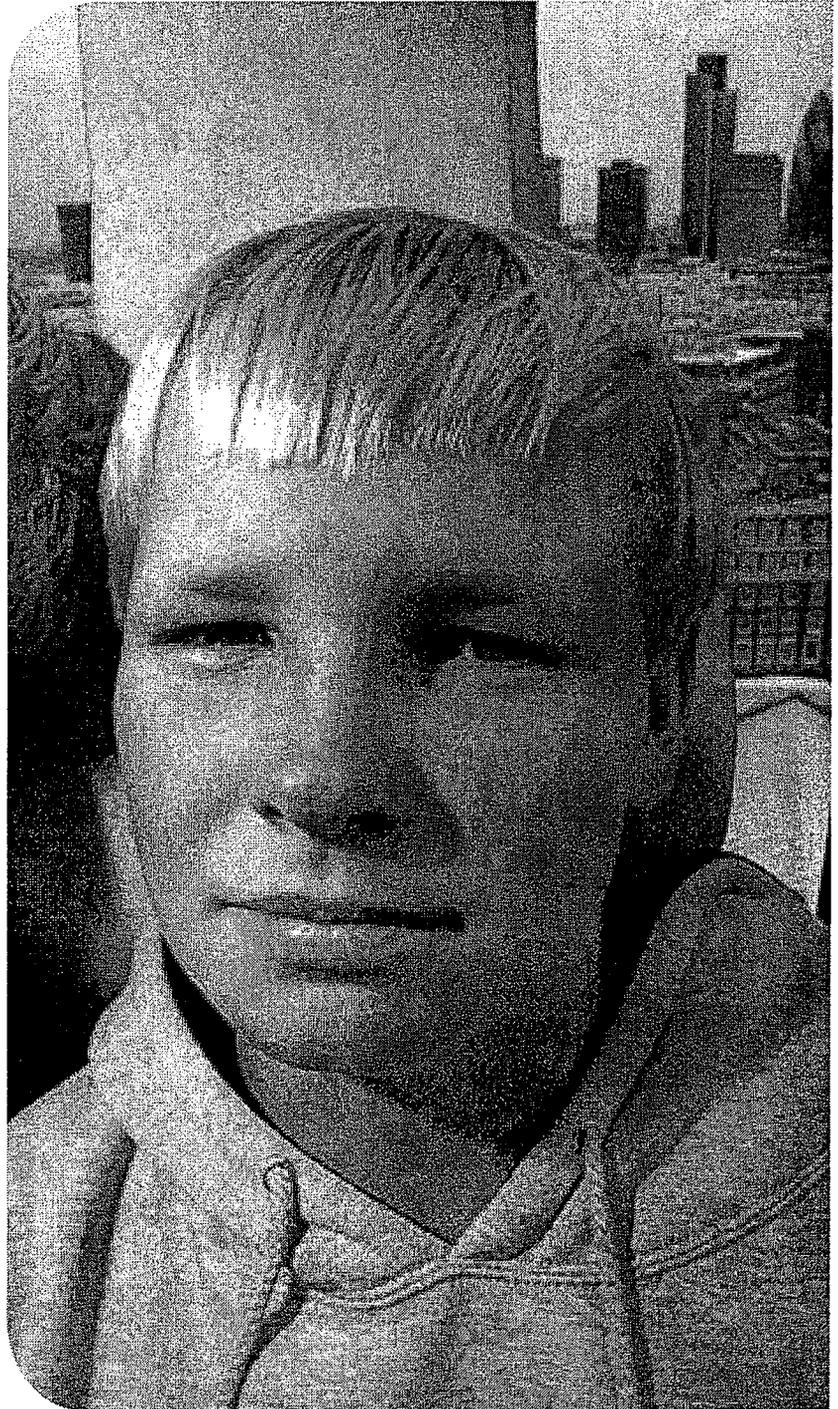
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Washington's CALL TO ACTION

First Star is appalled by Washington's grade. The Washington Legislature should, among other things:

- Require legal counsel for all children in all proceedings
- Require that all counsel be independent and client directed
- Establish respectable requirements for attorney training and multidisciplinary interaction
- Require that a child be considered a party entitled to notice, and be present in all child protective, foster care or dependency proceedings
- Require continuity of counsel, and that the appointment of the same legal counsel last throughout the appellate process and all subsequent reviews



APPENDIX D

**Prevent Child Abuse America
Chicago, Illinois**

**Total Estimated Cost of
Child Abuse and Neglect in the United States**

Ching-Tung Wang, Ph.D. and John Holton, Ph.D.

Child abuse and neglect are preventable, yet each year in the United States, close to one million children are confirmed victims of child maltreatment. An extensive body of research provides promising and best practices on what works to improve child safety and well-being outcomes and reduce the occurrence of child abuse and neglect. These efforts are essential as child abuse and neglect have pervasive and long-lasting effects on children, their families, and the society. Adverse consequences for children's development often are evident immediately, encompassing multiple domains including physical, emotional, social, and cognitive. For many children, these effects extend far beyond childhood into adolescence and adulthood, potentially compromising the lifetime productivity of maltreatment victims (Daro, 1988).

It is well documented that children who have been abused or neglected are more likely to experience adverse outcomes throughout their life span in a number of areas:

- Poor physical health (e.g., chronic fatigue, altered immune function, hypertension, sexually transmitted diseases, obesity);
- Poor emotional and mental health (e.g., depression, anxiety, eating disorders, suicidal thoughts and attempts, post-traumatic stress disorder);
- Social difficulties (e.g., insecure attachments with caregivers, which may lead to difficulties in developing trusting relationships with peers and adults later in life);
- Cognitive dysfunction (e.g., deficits in attention, abstract reasoning, language development, and problem-solving skills, which ultimately affect academic achievement and school performance);
- High-risk health behaviors (e.g., a higher number of lifetime sexual partners, younger age at first voluntary intercourse, teen pregnancy, alcohol and substance abuse); and
- Behavioral problems (e.g., aggression, juvenile delinquency, adult criminality, abusive or violent behavior) (Child Welfare Information Gateway, 2006; Goldman, Salus, Wolcott, & Kennedy, 2003; Hagele, 2005).

The costs of responding to the impact of child abuse and neglect are borne by the victims and their families but also by society. This brief updates an earlier publication documenting the nationwide costs as a result of child abuse and neglect (Fromm, 2001). Similar to the earlier document, this brief places costs in two categories: direct costs, that is,

those costs associated with the immediate needs of children who are abused or neglected; and indirect costs, that is, those costs associated with the long-term and/or secondary effects of child abuse and neglect. All estimated costs are presented in 2007 dollars. Adjustments for inflation have been conducted using the price indexes for gross domestic product published by the Bureau of Economic Analysis (<http://www.bea.gov>).

Based on data drawn from a variety of sources, the estimated annual cost of child abuse and neglect is **\$103.8 billion** in 2007 value. This figure represents a conservative estimate as a result of the methods used for the calculation. First, only children who could be classified as being abused or neglected according to the Harm Standard in the Third National Incidence Study of Child Abuse and Neglect (NIS-3) are included in the analysis. The Harm Standard requirements, compared to the Endangerment Standard requirements used in NIS-3, are more stringent (Sedlak & Broadhurst, 1996). Second, only those costs related to victims are included. We have not attempted to quantify other costs associated with abuse and neglect, such as the costs of intervention or treatment services for the perpetrators or other members of the victim's family. Third, the categories of costs included in this analysis are by no means exhaustive. As examples, a large number of child victims require medical examinations or outpatient treatment for injuries not serious enough to require hospitalization; maltreated children are at greater risk of engaging in substance abuse and require alcohol and drug treatment services; and youth with histories of child abuse and neglect may be at greater risk of engaging in risky behaviors such as unprotected sexual activities as well as greater risk of teen pregnancy. We were not able to estimate these types of costs as data are not readily available.

Although the economic costs associated with child abuse and neglect are substantial, it is essential to recognize that it is impossible to calculate the impact of the pain, suffering, and reduced quality of life that victims of child abuse and neglect experience. These "intangible losses", though difficult to quantify in monetary terms, are real and should not be overlooked. Intangible losses, in fact, may represent the largest cost component of violence against children and should be taken into account when allocating resources (Miller, 1993).

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Total Annual Cost of Child Abuse and Neglect in the United States
DIRECT COSTS

Direct Costs	Estimated Annual Cost (in 2007 dollars)
Hospitalization <i>Rationale: 565,000 maltreated children suffered serious injuries in 1993¹. Assume that 50% of seriously injured victims require hospitalization². The average cost of treating one hospitalized victim of abuse and neglect was \$19,266 in 1999³. Calculation: $565,000 \times 0.50 \times \\$19,266 = \\$5,442,645,000$</i>	\$6,625,959,263
Mental Health Care System <i>Rationale: 25% to 50% of child maltreatment victims need some form of mental health treatment⁴. For a conservative estimate, 25% is used. Mental health care cost per victim by type of maltreatment is: physical abuse (\$2,700); sexual abuse (\$5,800); emotional abuse (\$2,700) and educational neglect (\$910)⁴. Cross referenced against NIS-3 statistics on number of each incident occurring in 1993¹. Calculations: Physical Abuse – $381,700 \times 0.25 \times \\$2,700 = \\$257,647,500$; Sexual Abuse – $217,700 \times 0.25 \times \\$5,800 = \\$315,665,000$; Emotional Abuse – $204,500 \times 0.25 \times \\$2,700 = \\$138,037,500$; and Educational Neglect – $397,300 \times 0.25 \times \\$910 = \\$90,385,750$; Total = \$801,735,750.</i>	\$1,080,706,049
Child Welfare Services System <i>Rationale: The Urban Institute conducted a study estimating the child welfare expenditures associated with child abuse and neglect by state and local public child welfare agencies to be \$23.3 billion in 2004⁵.</i>	\$25,361,329,051
Law Enforcement <i>Rationale: The National Institute of Justice estimated the following costs of police services for each of the following interventions: physical abuse (\$20); sexual abuse (\$56); emotional abuse (\$20) and educational neglect (\$2)⁴. Cross referenced against NIS-3 statistics on number of each incident occurring in 1993¹. Calculations: Physical Abuse – $381,700 \times \\$20 = \\$7,634,000$; Sexual Abuse – $217,700 \times \\$56 = \\$12,191,200$; Emotional Abuse – $204,500 \times \\$20 = \\$4,090,000$; and Educational Neglect – $397,300 \times \\$2 = \\$794,600$; Total = \$24,709,800</i>	\$33,307,770
Total Direct Costs	\$33,101,302,133

¹ Sedlak, A.J., & Broadhurst, D.D. (1996). *The third national incidence study of child abuse and neglect (NIS-3)*. U.S. Department of Health and Human Services. Washington, DC.

² Daro, D. (1988). *Confronting child abuse: Research for effective program design*. New York: Free Press.

³ Rovi, S., Chen, P.H., & Johnson, M.S. (2004). The economic burden of hospitalizations associated with child abuse and neglect. *American Journal of Public Health*, 94, 586-590. Retrieved September 7, 2007 from <http://www.ajph.org/cgi/reprint/94/4/586?ck=nck>

⁴ Miller, T.R., Cohen, M.A., & Wiersema, B. (1996) *Victim costs and consequences: A new look*. The National Institute of Justice. Retrieved August 27, 2007 from <http://www.ncjrs.gov/pdffiles/victcost.pdf>

⁵ Scarcella, C.A., Bess, R., Zielewski, E.H., & Geen, R. (2006). *The cost of protecting vulnerable children V: Understanding state variation in child welfare financing*. The Urban Institute. Retrieved August 27, 2007 from http://www.urban.org/UploadedPDF/311314_vulnerable_children.pdf

Total Annual Cost of Child Abuse and Neglect in the United States INDIRECT COSTS

Indirect Costs	Estimated Annual Cost (in 2007 dollars)
Special Education <i>Rationale: 1,553,800 children experienced some form of maltreatment in 1993¹. 22% of maltreated children have learning disorders requiring special education⁶. The additional expenditure attributable to special education services for students with disabilities was \$5,918 per pupil in 2000⁷. Calculation: $1,553,800 \times 0.22 \times \\$5,918 = \\$2,022,985,448$</i>	\$2,410,306,242
Juvenile Delinquency <i>Rationale: 1,553,800 children experienced some form of maltreatment in 1993¹. 27% of children who are abused or neglected become delinquents, compared to 17% of children in the general population⁸, for a difference of 10%. The annual cost of caring for a juvenile offender in a residential facility was \$30,450 in 1989⁹. Calculation: $1,553,800 \times 0.10 \times \\$30,450 = \\$4,731,321,000$</i>	\$7,174,814,134
Mental Health and Health Care <i>Rationale: 1,553,800 children experienced some form of maltreatment in 1993¹. 30% of maltreated children suffer chronic health problems⁶. Increased mental health and health care costs for women with a history of childhood abuse and neglect, compared to women without childhood maltreatment histories, were estimated to be \$8,175,816 for a population of 163,844 women, of whom 42.8% experienced childhood abuse and neglect¹⁰. This is equivalent to \$117 [$\\$8,175,816 / (163,844 \times 0.428)$] additional health care costs associated with child maltreatment per woman per year. Assume that the additional health care costs attributable to childhood maltreatment are similar for men who experienced maltreatment as a child. Calculation: $1,553,800 \times 0.30 \times \\$117 = \\$54,346,699$</i>	\$67,863,457
Adult Criminal Justice System <i>Rationale: The direct expenditure for operating the nation's criminal justice system (including police protection, judicial and legal services, and corrections) was \$204,136,015,000 in 2005¹¹. According to the National Institute of Justice, 13% of all violence can be linked to earlier child maltreatment⁴. Calculations: $\\$204,136,015,000 \times 0.13 = \\$26,537,681,950$</i>	\$27,979,811,982
Lost Productivity to Society <i>Rationale: The median annual earning for a full-time worker was \$33,634 in 2006¹². Assume that only children who suffer serious injuries due to maltreatment (565,000¹) experience losses in potential lifetime earnings and that such impairments are limited to 5% of the child's total potential earnings². The average length of participation in the labor force is 39.1 years for men and 29.3 years for women¹³; the overall average 34 years is used. Calculation: $\\$33,634 \times 565,000 \times 0.05 \times 34 = \\$32,305,457,000$</i>	\$33,019,919,544
Total Indirect Costs	\$70,652,715,359
TOTAL COST	\$ 103,754,017,492

⁶ Hammerle, N. (1992). *Private choices, social costs, and public policy: An economic analysis of public health issues*. Westport, CT: Greenwood, Praeger.

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