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**Valuing Substitute Families:
Financial Support for Foster
and Adoptive Families**

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Valuing Substitute Families: Financial Support for Foster and Adoptive Families *

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Abstract

We examine current child welfare policy meant to encourage families to do the caring labor of fostering and adopting. Existing subsidy policy does not adequately insure foster and adoptive families against the financial risk associated with caring for children who have been victims of abuse or neglect. We call for a recasting of exiting programs as insurance. An insurance program would protect current substitute families and would attract additional substitute families who currently do not participate because of the “doing it for the money” stigma that surrounds the existing program.

Key words: adoption, caring labor, child welfare policy, foster care, insurance, subsidy

JEL classification: J13, J18, I38

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Valuing Substitute Families: Financial Support for Foster and Adoptive Families

Caring is risky. Consider the emotional and economic uncertainty inherent in caring for a child born to you. Your child may be healthy or may have a birth defect that requires lifelong medical treatment. Your child may be easy to live with or may be challenging or troubled. Your child may take care of you in your old age or she may be disabled in an accident. In the United States, caring for a child is made more difficult because of inadequate child care policy and uneven health insurance coverage. Even with insurance, caring for a child with extraordinary needs can bankrupt a family. Mental and emotional health needs are particularly problematic because insurance coverage for these needs is spotty; consequently, providers are few.

Now consider the challenges of a family that cares for a child who has been removed from his or her birth family because of abuse or neglect. The current health of the child may be poor; the health history of her birth family may be unknown. The child may have experienced deprivation or terror, but may never have experienced comfort and love. The child may be developmentally delayed, and it may take years of therapeutic intervention before her potential for development can be meaningfully assessed.

The care of this child may not be your responsibility, directly. But if this child is not well cared for by a substitute family—a foster or adoptive family—in the long run we will all support the adult this child grows to be. We will support her through the taxes we pay to run the prison or psychiatric facility where she may live out most of her life. One of us may even be the victim of a crime she perpetrates if she is unable to find a place in society or the economy. If parenting is

public service (Nancy Folbre 1994: 86), then substitute parenting through fostering and adopting is extreme public service.¹

The foster and adoptive families that care for these young victims of abuse and neglect are frequently scrutinized (e.g. *USA Today*, April 24, 2007, A1). Even defenders of children and families find fault with “the child welfare system” in the U.S. (Sylvia Ann Hewlett and Cornel West 1998). While the child welfare system surely has its problems, it is comprised mainly of substitute families trying to undo the effects of some of life’s greatest injustices. The children, of course, cannot speak for themselves. They cannot decide if they need occupational or speech therapy; they cannot negotiate the complex of medical and mental health services; they cannot write their own individualized programs for special education. If we want to sustain and encourage the efforts of substitute families, we should actively pursue policy that insulates them against the risks of caring.

Some substitute families have spoken out using what Cameron Lynne MacDonald and David Merrill (2002) term the “vocabulary of skill.” By signaling their commitment through credentialing and willingness to take on the most challenging of children (P.H. Defabro and J.G. Barber 2004), they have successfully professionalized their work. But these substitute parents/care professionals are still relatively rare. Most are simply families.

The federal policy for financial support of substitute families was codified in the Adoption Assistance and Child Welfare Act of 1980, which established Title IV-E of the Social Security Act. Title IV-E provides federal matching funds for states that offer monthly subsidies to substitute

¹ The care work of substitute families have thusfar been omitted from the economic literature on caring labor that has eloquently addressed child care (e.g. Jane Jenson and Mariette Sineau 2001) and elder care (e.g. Susan C. Eaton 2005). Sociologists have done more research on substitute parenting as care work (e.g. Teresa Toguchi Schwarz 2004).

families. Title IV-E is a program of monetary incentives that encourages families to form a bond with children born to but victimized by another.

Congress intended that the neediest children should have the most certain access to substitute families and that the standard of living of substitute families should not be reduced by their caring. But there is inconsistency between the original intent of the law and its workaday implementation. The level of support received by many substitute families is so low that children do without services that they need, especially expensive mental and behavioral health services. Another inconsistency is the existence of the so-called *lookback* provision in the determination of which children are eligible for federal support. In order for a state to be able to claim federal reimbursement for any foster care and adoption expenses, most children must have experienced material deprivation in her original, birth family. The law defines material deprivation in terms of eligibility for Aid to Families with Dependent Children. Of course, because AFDC was replaced by the Temporary Assistance for Needy Families, AFDC eligibility criteria are no longer updated. However, the lookback to AFDC has never been removed from child welfare law, and so today only children whose birth families are so poor that their income is at or below 1996 AFDC limits are eligible for federal monies. States wishing to continue to support substitute families will see a substantial increase in their fiscal obligations if there is no change in the federal definition of Title IV-E eligibility. A 2004 Pew Commission report suggested de-linking adoption assistance from the out-dated AFDC criteria. Most recently, Sen. John D. Rockefeller (D-WV) introduced S. 1539 (“A bill to amend part E of title IV of the Social Security Act to promote the adoption of children with special needs”) on July 28, 2005. Rep. Benjamin Cardin (D-MD) introduced H.R. 1534 (“Child Protective Services Improvement Act”) on April 1, 2003. Rep. Herger introduced H.R. 4856 (“Child Safety, Adoption, and Family Enhancement Act”) on July 19, 2004. However, none of these bills emerged from committee. The unresponsiveness of the law to the needs of the children and of

the families who care for them reveals the need for a change in how we think about and finance the care of our most vulnerable children.

In the absence of a well-developed and universal insurance program covering physical, mental, and behavioral health needs, it remains imperative to provide financial support to substitute families in order to encourage their participation in fostering and adopting. We argue, though, that an insurance model more accurately reflects Congressional intent. Such insurance would encourage specialized therapeutic service providers to offer more of the kinds of care that is needed. Further, by transforming the current “assistance,” “subsidies,” and “maintenance payments” into insurance, we would attract additional substitute families who currently do not participate because of the “doing it for the money” stigma that surrounds the existing program.

This is an unconventional essay. We speak for others, but we also speak from experience. One of the authors is the parent of three children adopted after abuse, neglect, abandonment, and years in foster care. The children have problems stemming from their early experiences that range from mild (such as sensory integration disorder that makes one child much more sensitive to textures than most children) to severe (one child has fetal alcohol syndrome, brain damage that impairs her understanding of the chain of cause-and-effect). That author is also a parent of two children by birth who have no disabilities. The author’s family currently faces a choice between paying for residential psychiatric and behavioral therapy for one daughter and paying for college for another daughter. In which daughter’s future should the author invest? This is the kind of decision that current policy forces substitute parents to make.

The Current Policy Picture

There were 872,000 substantiated reports of child abuse and neglect in the U.S. in 2004 (US Department of Health and Human Services [DHHS] 2006a). More than 800,000 children will spend

at least part of the year in a foster family because their birth families cannot provide safe and adequate care (US DHHS 2006b). On a given day, over half a million children in the U.S. live with foster families. More than 100,000 of these children need permanent substitute families; they need to be adopted (US DHHS 2006b). The number of minors ever adopted from foster care nears a half million (Fred Wolczyn and Kristin Hislop 2002). These numbers imply that about 1 of every 100 children in the United States is cared for by a substitute family at some time.

Worldwide the needs of children are even greater. The United Nations (2006) reports that as many as 53,000 children were victims of homicide in 2002; most died at the hands of their parents. One third of children suffer serious injury as the result of corporal punishment. Over 225 million children suffer sexual abuse.

When the victim of abuse or neglect is the child of the perpetrator, we, as a society, step in to protect the child. A child victim receives immediate protection in the home of an emergency foster family. If the charge of abuse or neglect is substantiated through an investigation by child protective services, and if the court finds the child cannot be returned home safely without further intervention, the child may be placed with a *long-term* foster family. Foster parents protect and nurture the child and, at the same time, support the efforts of the child welfare system to reunite the child with the birth family.

Reunification of the child with the birth family requires that the birth parent(s) cooperate with interventions provided by child protective services and other parts of the social service system. Interventions may include, but are not limited to, parenting and anger management training, mental health treatment, and drug or alcohol rehabilitation. Supporting services may include temporary housing and assistance in enrolling in housing programs, health insurance via state Medicaid programs, and income support programs. Once child protective services can no longer support a claim that the child's best interests are served through protection by the state in a foster family, the

interests of the birth family in the care and companionship of the child supersede, and the child is reunited with her birth family. The child welfare system thus aims to maximize the well-being of society through simultaneous protection of the interests and rights of the child and the interests and rights of the birth family.

If the threat of harm to the child from the birth family is not mitigated through the interventions, then the child welfare system petitions the court to terminate the parental rights of the birth parents, and the child welfare system seeks a permanent substitute family for the child. Alternatives for permanency include legal guardianship and adoption. Adoption is the preferred alternative for most children. Child welfare caseworkers may recruit the foster family, members of the child's extended family, close friends of the family, or previously unrelated adults to adopt.

Most countries recognize this right of the child to experience the benefits of being cared for by a loving family; a right articulated in the United Nations Convention on the Rights of the Child (Preamble and section 20), which has been ratified in full or in part by 192 countries as of 2004 with the exception of the United States and Somalia. Therefore, most governments recognize that society must assume the responsibility of finding and supporting loving substitute families for child victims of abuse and neglect. First under Aid to Families with Dependent Children, and since 1980 under Title IV-E of the Social Security Act, the federal government of the U.S. has provided matching funds to states that provide payments for the maintenance of eligible children in foster care (US DHHS 2005).

When the author's daughter Jenny first entered foster care, her birth parents had been jobless and homeless most of her life. Jenny was just over three years old, was developmentally delayed, was prone to violent tantrums, and had symptoms of post-traumatic stress disorder. She also was of mixed racial heritage. In her home state, any of these traits, in combination with the material deprivation of her early life, made Jenny *Title IV-E eligible*. At the rates then in effect, the

state was able to claim reimbursement for 51.67% (US DHHS 2006c) of her monthly maintenance payments of \$294 paid to Jenny's foster family (National Resource Center for Family Centered Practice and Permanency Planning [NRC] 2006).

The federal share of the cost of foster care during fiscal years 2001 to 2003 ranged from \$4,100 to \$33,100 per child in care (US DHHS 2005), depending on the state. In their abbreviated discussion of substitute families, Sylvia Ann Hewlet and Cornel West (1998: 111) make it sound as though these monies all go directly to foster parents. But at least \$2.5 million in federal spending annually is not payments to substitute families, but reimbursement for administrative costs (US GAO 2006).

In most states, foster care maintenance payments to families do not go very far in covering the everyday expenses of the children. Consider the ratio of the monthly foster care maintenance rate in the state (NRC 2005) to the USDA (2005) estimate of the average monthly expenditures per child by average income families. The ratio in the average state was .53 in 2004.² That is, on average, foster care maintenance barely covers half of the average costs of raising the average child. Figure 1 shows the distribution of the ratio. The ratio ranges from lows of .3 to .4 in Colorado, Idaho, Louisiana, Missouri, Nebraska, Rhode Island, South Carolina, and Wisconsin, to a high of about 90 percent in the District of Columbia.

Providing care for a child with special physical, emotional, or behavioral needs is more expensive than providing care for the average child. While no existing study for the U.S. confirms this intuition directly, an Australian study shows that a child in foster care there has greater expenses

² Substitute parents in the U.K. are similarly treated. Recent estimates indicate that the government expenditures on foster care in the U.K. cover only about 60 percent of the needs of the children (Robert Tapsfield and Felicity Collier 2005).

than the average child (M. McHugh 2002). Studies of the costs of specific disabilities provide additional supporting evidence. For example, the estimated cost of raising a child with fetal alcohol syndrome is \$2 million (C. Lupton, L. Burd, and R. Harwood 2004).

Foster mothers explain that the children come into care with very little. They pride themselves on provisioning foster children as they would birth children (Danielle F. Wozniak 2004: 88). In a study of foster parents associated with an agency in Los Angeles County, Teresa Toguchi Swartz found that, despite the working-class socio-economic status of most foster families, they “regularly spent more money on the children than the[ir state] stipends provided” (Swartz 2004: 575-6).

Financial assistance programs for families who adopt children from foster care emerged in the states in the 1970s. The programs flowed from confluence of three trends in child welfare (Andrea Sedlak and Diane Broadhurst 1993). First, the child welfare system began to plan for permanent placement of child victims of abuse and neglect with a substitute family; second, advocates of adoption rallied around the motto “all children are adoptable;” third, the importance of the role of foster families in the lives of children was recognized. States that encouraged foster families to consider adoption took the lead in the development of adoption assistance: obviously foster families had a disincentive to adopt if adoption meant the withdrawal of financial support and services. Moreover, since the federal government did not contribute to early state adoption programs, but did contribute to foster care programs, there was an administrative disincentive to move children into adoptive families.

The federal adoption subsidy program, again,, was added to the Social Security Act in 1980 as part of Title IV-E. Since then, adoptive parents of former foster children have received a monthly subsidy payment, provided the child has a severe disability, or a state-designated special need coupled with material deprivation in her birth family. Most Title IV-E eligible children also

receive Medicaid. Adoptive families of eligible children can receive assistance with the up-front costs of adoption, including expenses related to the home study and legal fees. Beginning in tax year 2003, adoptive families of eligible children receive a one-time tax credit of \$10,000 to help establish the child's place in the family home (P.L. 107-16). While this is substantial, the support offered still fails to meet the needs of some substitute families: Some families need to purchase larger vehicles or larger dwellings to accommodate a larger family; some families need to create accessible spaces in the home; most substitute families must reduce work hours to attend to the child's needs. Each state, and in some states, each local jurisdiction, has its own rules regarding what specific services can be paid for with adoption subsidy after finalization of the adoption. There is no central data source describing these services.

Adoption assistance in the average state provides less than foster care maintenance payments. Consider the ratio of the basic adoption subsidy rates (this is, the rate the state "advertises" publicly) to the average spending on children (North American Council on Adoptable Children [NACAC] n.d, USDA 2005). The ratio in the average state is .51, slightly lower than the ratio for foster care maintenance rates. In Arizona, for example, foster families are reimbursed almost three quarters of the cost of raising the average child, but adoptive families of eligible children are reimbursed only a third of the cost of a child. About 47 percent of adoptive families in a recent survey report that they adopted a foster child even though they experienced a loss of financial support (Children's Rights 2006: 8).

When the author's family accepted placement of Jenny for adoption in 2003, when she was nearly seven years old, the family received the same monthly adoption assistance rate (\$296 per month) as the foster family had received. In addition to provisioning Jenny with additional age-appropriate clothes, toys, and furniture, the family quickly arranged for Jenny to receive occupational therapy to address her delays in gross and fine motor skills and play therapy (a form of

psychotherapy) to address her symptoms of mood and stress disorders. While some of these services were covered by insurance, with a high co-payment, much was not. For many services, Medicaid providers were unavailable or available only at great distances. If the expense was not covered by insurance, it was possible to petition for reimbursement from the department of social services. Some bills the department paid, others it did not. It was not possible to obtain guarantees of payment in advance from our local department, although it is possible in some jurisdictions to petition for an increase in the monthly subsidy to cover ongoing expenses.

The evidence is that most foster and adoptive families generally do not profit from their care work. Most substitute families spend more per child than they receive in subsidy. This is confirmed by government-contracted studies, studies conducted by non-profit research organizations, and academic studies. A study of the adoption assistance program commissioned by the Department of Health and Human Services in the 1980s revealed that over half of substitute parents were sometimes unable to provide needed care because of a lack of funds (Sedlack and Broadhurst 1993: 6-59-61). The parents said: “The financial burden is becoming overwhelming”; “[took] a second mortgage on the house”; “[worked] about 20 hours extra per week for four years”; “[m]ore tension between my wife and I [sic].” A more recent survey conducted by Children’s Rights reveals little has changed. Fifty-seven percent of adoptive families surveyed reported that adoption assistance was insufficient to meet the child’s needs (Children’s Rights 2006: 9).

The US General Accounting Office [GAO] (2006) described the Title IV-E programs vaguely as providing financial support for the care of eligible children in substitute families. But the federal adoption subsidy program was specifically intended to remove the fiscal disincentive that states faced in the provision of permanent substitute families and to connect eligibility for federal funding to the characteristics of the child to be adopted rather than the characteristics of the substitute family (Sedlak and Broadhurst 1993). The program was not meant to be merely income

support. In fact, the law forbids means testing of the substitute family in the determination of eligibility or size of payment (US DHHS 1990), and a recent court decision has affirmed that states may not treat assistance for substitute families as a form of welfare by instituting means tests (*E.C. v. Blunt* (05-0726-CV-W-SOW)). Federal funding for foster care emerged from a similar desire to encourage states to protect child victims of abuse and neglect and to give incentives to families to open their homes to those children in need (US DHHS 2005).

Assistance to substitute families is meant to “minimize the financial obstacles” of caring (Child Welfare Information Gateway 2004) by protecting the members of the substitute families who step forward to raise children with special needs. In the words of Richard Barth, renowned child welfare scholar, the adoption subsidy was intended to enable a substitute family “to be able to adopt a child without having to lower its standard of living” (Richard Barth 1993: 21, see also Barth et al. 2003: 4).

The generosity of support for substitute families is positively associated with the number of families who step forward (Mary Eschelbach Hansen and Bradley Hansen 2006, Delfabbro and Barber 2004). Inadequate support for substitute families depresses the number of people who are willing to assume the responsibility of caring for the children. Low levels of support signal that society places little value on the care of the children, which in turn may reduce the value that families see in the work. In the words of Nancy Folbre (1994: 88): “Failure to remunerate commitments to parental labor may weaken the values, norms, and preferences that supply it.”

Of course, the familiar issue of quality, of love versus money, is apparent. As in blood donation (Richard Titmuss 1970; see also Bruno S. Frey 1997), there is fear that increasing support for substitute families attracts families of lower quality who take on their responsibilities “for the money” or that government provision of the work crowds out private provision of it. Substitute families regularly field accusations of profiteering (Sedlak and Broadhurst 1993: 6-13; Swartz 2004:

582). Most substitute parents, however, take on their responsibilities as a moral commitment. Substitute families see themselves as “producers of social healing and guardians of society’s future” (Wozniak 2004: 80).³

The supply of foster and adoptive families is responsive to government subsidies of their activities (Hansen and Hansen 2006, Delfabbro and Barber 2004), so it is likely that in this case economic and altruistic motivations work in tandem (Nancy Folbre and Julie Nelson 2000, Julie Nelson 1999, Clare Ungerson 1990, Kari Waerness 1984). Nancy Folbre and Julie Nelson (2000) argue, in fact, that payment for care can initiate caring relationships (see also Folbre 2001 and Paul England, Michelle Budig, and Nancy Folbre 2002). This can be the case when the home health care worker cares for the homebound, when the home-based child care provider who becomes like a beloved “aunt” for the child, and when the family that chooses to adopt or foster. Moreover, the larger the number of families that choose adoption, the easier it will to match the strengths of substitute families with the needs of the children.

The Children in Substitute Families

Little is known about the physical, mental, and behavioral health needs of the children in foster care in the U.S., but it is clear that many of the children in foster care have physical or

³ Note that our argument is consistent with the idea that the institutional features associated with care and its pay directly influence the quality of care (Emily Abel and Margaret Nelson 1990, Francesca Cancian 2000, Agneta Stark 2005, Swartz 2004, Ungerson 1990). See also England and Folbre (2003), Alabert Evers, Marji Pijl, and Clare Ungerson (1994), Madonna Meyer Harrington (2000). For a psychological perspective of altruism as motivation, see Jeylan Mortimer and Jon Lorence (1995)

psychological problems as a result of experiences including pre-natal exposure to alcohol or drugs, neglect or abuse, and multiple foster care placements (US GAO 1995). It is believed that 30 to 40 percent of children in the child welfare system have physical health problems (Penelope Maza 2001). Experts disagree on the number of children in foster care who have psychiatric and behavioral disorders. The Child Welfare League of America [CWLA] (n.d.) reports that about “60 percent of all children in out-of-home care have moderate to severe mental health problems ... Adolescents living with foster parents or in group homes have about four times the rate of serious psychiatric disorders than those living with their own families.” Foster children are more likely than other groups of Medicaid children to use mental health services (US DHHS 2000, Margo Rosenbach 2001).

The 2000 census has information about adopted children in general, and the administrative records from the Adoption and Foster Care Analysis and Reporting System [AFCARS] includes information about the special needs of the children who are adopted from foster care. The children who join permanent substitute families are very likely to have one or more special needs.

The federal Census of 2000 was the first census to collect data on *adopted son/daughter* separate from *natural born son/daughter* and *stepson/stepdaughter* (Rose Kreider 2003). The *adopted* category includes all kinds of adoption—adoption of kin, of stepchildren, adoption through private and public agencies, domestic and international adoption, and independent and informal adoption. The census enumerated 2.1 million adopted children, who represented about 8 percent of all sons and daughters of householders in 2000. About 1.8 percent (817,000 households) contained only adopted children. Another 1.8 percent contained both adopted children and birth children.

About 5.2 percent of birth children aged five to 17 were reported to have a disability, while 11.8 percent of adopted children were reported to have a disability. Householders reported that just less than one percent of birth children had a sensory, a physical, or a self-care disability, while they reported about 1.5 percent of adopted children had disabilities that fell into one of those categories.

Mental disabilities included learning disabilities and difficulties concentrating. About 4 percent of birth children and 10.4 percent of adopted children were reported to have a mental disability.

Adopted children were more than twice as likely to have multiple disabilities.

Less than 15 percent of the 323,500 adoptions from foster care from 1996 through 2003 involved a child who did *not* have a *special need* (author's calculation from AFCARS public use adoption data). Again, a special need is a state-defined characteristic that makes placement more difficult; older age was the most common (or perhaps the most easily documented) special need of almost 75,300 adopted children (almost 24 percent of valid observations) because most families would prefer to adopt a younger, rather than an older, child. Needing to be placed with one or more siblings was the special need of about 53,700 adopted children (17 percent of valid observations). Over 64,000 adopted children had a medical condition or physical disability (about 20 percent of valid observations). About 10,600 children (13.6 percent) had a special need that fell outside these categories.

The top panel of figure 2 shows the trends in the recorded special needs of children adopted after foster care. From 1996 to 2003, the number of adopted children having no special need dropped precipitously. Children who had a special need because of a medical condition or disability increased from 14 to 24 percent of adoptions. The percentage of adopted children with a physical or sensory disability climbed from 3.3 percent (just over 400 children) in 1996 to almost 5.3 percent (1,600 children) in 2003.

The special needs category of medical condition or disability includes children with disabilities of *emotional disturbance* or *another diagnosed condition*. The bottom panel of figure 2 shows trends in these two categories of disability. The percentage of adopted children with an emotional disturbance increased from about 5.5 percent in fiscal years 1996 and 1997 to 8.3 percent in 1998 and to 12.7 percent in 2003. For comparison, the National Center for Education Statistics [NCES]

(2004) reports that emotionally disturbed students were about 1 percent of the student population throughout the period. The percentage of adopted children with some other disabling condition, which could include learning disability or psychiatric diagnosis such as attention deficit/hyperactivity disorder, a mood disorder, or post-traumatic stress disorder has increased from an average of 9 percent for 1996-1997 to 13.7 percent in 1998 and 18.2 percent in 2003. Among all pre-school to secondary school-age children, about 6.0 percent had a learning disability during the period (NCES 2004).

These statistics almost certainly underestimate the special needs of children in substitute families because the child welfare agencies do not have, or do not report, complete information about the children. Jenny's story illustrates the point. Jenny's case history indicated that her birth parents had been homeless for most of the first three years of her life, at which point she was taken into care. Her birth father had been jailed on drug charges, but her birth mother claimed not to have used drugs or alcohol. Jenny's school records indicated that she experienced cognitive impairments and needed special education. Her evaluations at a Medicaid-financed child development clinic did not indicate a specific cause for her impairments. Jenny had been in foster care for three years before the court terminated her birth parent's rights, but her foster family was unwilling to adopt her.

Jenny had not received any mental health care during her stay in foster care. This is not unusual; less than one-third of children in foster care receive mental health care (US GAO 1995). One of the first things the author did was take Jenny to a child and family therapist, who referred her to a neuropsychologist. The neuropsychologist diagnosed fetal alcohol syndrome. Today, as a preteen, Jenny exhibits signs of a serious mood disorder, but she has violent reactions to medications. In-home, family-based therapies have not helped. Jenny's executive functioning is so inadequate that she cannot be safely let out of the sight of an adult; she poses a danger to herself and

her siblings. Jenny's psychiatrist referred her for inpatient evaluation and therapy. Funding for this care was denied by the author's private insurance company, by Medicaid, by the Department of Social Services, and by the state-run "comprehensive services" funding source for at-risk youth.

One public health case manager suggested that, if the author is unable to care for Jenny at home and is unable to pay the full cost of her inpatient care, then the next step should be to petition the judge to dissolve the adoption.

Obviously, dissolution is not in Jenny's best interest. She needs care. As her substitute parent, the author knows best what kind of care she needs; a new foster family would not be in a position to make good decisions about her care. Yet, there is a problem: that same author has another daughter who is set to begin college soon. If Jenny's inpatient care must be financed out-of-pocket, the other daughter's college expenses will drive the author's family deeply into debt.

It is tempting to argue that a family who fosters, or especially one that adopts, understands and accepts the financial risks. Said one adoptive parent: "The Director of the State Subsidy said basically we did not need subsidy because you did not get subsidy for a biological child, why should you get it for an adopted child?" (Sedlack and Broadhurst 1993: 6-53). But, again, consider Jenny's story. Her birth mother lied about Jenny's exposure to alcohol. As a result of the lie, neither the social workers nor the doctors who examined Jenny looked for the markers of fetal alcohol syndrome.

The case history of children who need substitute families is often incomplete. Less than half of adoptive parents in the 1980s reported that they found out about the extent of their adopted children's needs from the placing agency (Sedlack and Broadhurst 1993: 6-31). Only physical needs were adequately disclosed; special educational and emotional needs were disclosed only about one-third of the time (Sedlack and Broadhurst 1993: 6-32). Substitute parents volunteered statements

such as: “We were not told all the truth. We got a lot of misinformation” (Sedlack and Broadhurst 1993: 6-33).

The Contribution of Substitute Families

Despite the risks, one in three adults in the United States has considered adoption as a way to start or expand a family; one in five has very seriously considered adoption (Harris Interactive 2002). The 1995 National Survey of Family Growth indicated that nearly 10 million women had considered adoption and more than 1 million had taken steps to adopt (A. Chandra, J. Abma, P. Maza, and D. Bachrach 1999). Interest in adoption is, of course, influenced by fertility and fecundity (Chandra et al. 1999), and a significant number of foster and adoptive families care for members of their extended families (US DHHS 2006b). Nonetheless, since the 1960s some families have self-identified as *preferential* fosterers and adopters; that is, they do not have impaired fecundity, but they choose to become parents through fostering and adoption out of altruism or civic-mindedness (William Feigelman and Arnold Silverman 1983).

While most adults surveyed say they prefer younger and healthier children, 15 percent say that they would be likely to consider caring for a child with problems, and 28 percent say they would be likely to consider caring for a child who waits in foster care.⁴ The organizations that recruit adoptive families for children waiting in foster care receive hundreds of thousands of inquiries each year. The National Adoption Center, for example, receives over 40,000 calls per year; about one

⁴ The authors thank Rita Soronen of the Dave Thomas Foundation and Jon Siegel of Harris Interactive for their assistance in obtaining the 2002 Adoption Attitudes Survey. Also see Chandra et al. (1999).

third of callers are specifically interested in adopting a child from foster care (Julie Wilson, Jeff Katz, and Rob Geen, 2005).

Like other caring work (Folbre 1994, 2001; Julie Aslaksen, Charlotte Koren, and Marianne Stokstad 2000), the work of substitute families has positive externalities. The social benefits of fostering and adopting are greater than the private benefits.

The benefit of safety to the child is, of course, inestimable. Foster care literally saves the lives of some of the children it serves. Without the availability of safe substitute families, the number of infanticides would likely be much higher than the 550 to 600 per year that we have seen in the U.S. over the last decade (US DOJ 2006). There is little existing research on the benefits of fostering, but we do know that when children are removed from dysfunctional or neglectful environments and subsequently placed in functioning families, they experience significant catch-up. Catch-up effects have been measured for victims of abuse and neglect (A. Kadushin 1967) and for children rescued from overcrowded orphanages (Michale Rutter and the English and Romanian Adoptees Study Team 1998). Children are not more likely to be abused in foster families than in the average family (Richard Gelles 1996), the rare, but highly publicized, cases notwithstanding. If the public benefit of caring for the average child is large, if hard to quantify (Folbre 1994), then the public benefit of caring for a foster child is larger still.

For children who need permanent substitute families, adoption confers greater benefit than long-term foster care (Richard Barth 1997, Mary Eschelbach Hansen 2006, Alan Rushton 2004, John Triseliotis 2002, Marianus van Ijzendoorn, Femmie Juffer, and Caroline W. Klein Poelhvis 2005). Although the adopted, on average, do not do quite as well as the average child raised by his or her birth family, the adopted have better average outcomes than the fostered.⁵

⁵ See Hansen (2006) for additional details and a discussion of selection bias in adoption.

The reason why the adopted do better than the fostered is clear: “It is inconceivable that [legal] insecurity has not influenced the relationship between foster parents and the children” (Michale Bohman and Soren Sigvardsson 1990); and “by its very nature, the foster parent/child relationship implies a warning against any deep emotional involvement with the child” (*In re G.C.*, 735 A.2nd 1226 (Pa. 1999), quoted in Naomi R. Cahn and Joan Heifetz Hollinger 2004: 101). Adoption “offers higher levels of emotional security, sense of belonging and general well-being” (Triseliotis 2002).

Adoption greatly improves cognitive and educational outcomes compared to what the pre-adoptive environment of the child would predict. Health outcomes are improved as well, but the evidence on the mental health effects of adoption is mixed. The adopted are more likely to seek mental health services, but epidemiological studies (e.g. Russell M. Viner and Brent Taylor 2005) do not reveal a clear difference in the mental health of the adopted compared to the population.

Whatever the difficulties presented by adoption, the social and economic outcomes of adoption are positive. The adopted are 21 percent less likely than those fostered long-term to be suspended or expelled from school, are about half as likely to be delinquent or arrested, and are 32 percent less likely to be incarcerated. The adopted are more self-sufficient as young adults than the fostered. They are 24 percent less likely to be unemployed; they have higher incomes (after adjusting for higher school attendance rates); they have lower incidence of welfare program participation (see Hansen 2006).

The only existing cost-benefit analysis of adoption finds that each dollar spent returns from \$2.45 to \$3.26 in benefits to society (Hansen 2006). About one third of the benefits are private benefits that accrue to the adopted person in the form of higher wages. The remaining two thirds are public savings from reduced child welfare costs and reduced criminality. Clearly the children and society benefit from the caring labor of substitute families.

Of course, the caring labor performed in substitute families is the same caring labor performed in other families, but the financial (and possibly emotional) risks are greater. Because they care for children who had rocky starts while in the care of others, substitute families are more likely than the average family to encounter the most burdensome costs associated with caring.

Insuring Care, Ensuring Better Outcomes

Providing insurance for care improves outcomes. A large literature documents that expanding health insurance coverage improves health outcomes for a diverse subset of populations (e.g. Dana P. Goldman, Jayanta Bhattacharya, Daniel F. McCaffrey, Naihua Duan, Arleen A. Leibowitz, Geoffrey F. Joyce, and Sally C. Morton. 2001, Frank Lichtenberg 2002, Janet Currie and Jonathan Gruber 1996a and 1996b, Maria Hanratty 1996). Nearly all studies show that insurance coverage, whether privately or publicly provided, increases access to services compared to a state of being uninsured. For example, M. Susan Marquis and Stephen H. Long (1996) find that, for given health status, Medicaid beneficiaries use more ambulatory and inpatient care than they would without any insurance. John Z. Ayanian Joel S. Weissman, Eric C. Schneider, Jack A. Ginsburg, and Alan M. Zaslavsky (2000) note that, compared to those insured, individuals who have been uninsured for more than a year are more than three times as likely (26.8 versus 8.2 percent) to report not being able to see a physician when needed due to cost. These figures are magnified for those in poor health—69.1 percent of the long-term uninsured versus 21.8 percent of the insured were unable to access a physician when their health worsened.

The research on the importance of insurance for mental, emotional, and behavioral health outcomes is especially important here. D.D. McAlpine and D. Mechanic (2000) find that individuals covered by public programs are over six times as likely as the uninsured to receive mental health services. A.J. Davidoff, A.B. Garrett, D.M. Makuc, and M. Schirmer (2000) report that children who

are eligible for Medicaid but unenrolled have lower rates of access to and utilization of services compared to their enrolled counterparts. Paul W. Newacheck, Margaret McManus, Harriette B. Fox, Yun-Yi Hung, and Neal Halfon (2000) note that uninsured children with disabilities are less likely to have identified a clinician as a usual source of care, more likely to report unmet health care needs, and less likely to have had a physician visit in the last year.

The extent to which utilization of services increases depends upon the level of coverage provided by insurance. The RAND Health Insurance Experiment provides the most robust evidence (Joseph Newhouse and the Insurance Experiment Group 1993). Conducted over the course of several years beginning in the 1970s, families were randomized into plans with various cost-sharing arrangements (e.g., coinsurance rates ranged from 0 percent to 95 percent, and maximum dollar expenditure between 5 and 15 percent of income up to \$1,000). As cost-sharing levels increased, service usage fell in nearly every category, without the most noticeable adverse impact on health experienced by the most vulnerable subgroups.

But more is needed than simply an improved method of paying for the explicit costs of caring for children in substitute families. We must insure that adequate investments are made in the children at highest risk of becoming dependent adults. We provide insurance for the investment in children of the working population through other parts of the Social Security Act. If a person becomes unable to work, that person receives disability benefits to replace lost income so that he can continue to make investments in his or her children. If a worker dies, his or her dependents receive survivor's benefits. These benefits are tied to the national average wage, ensuring that the families of disabled or deceased workers share in the prosperity of the country. No such assurance is offered to the children whose parents are unable to care for them. In fact, if a child's parents abuse or neglect her, but their income is not sufficiently low, or if the child does not readily meet the

state's definition of *special needs*, then the federal system does not assure *any* investment in the child's future.

In their day-to-day work, advocates for adoption of child victims encourage prospective substitute families to view the adoption assistance subsidy program and post-adoption services as “essential parts of a post-adoption support plan for a child who either has, or is at risk to develop, some special needs.” (Adoption Policy Resource Center 2006, Rita Laws and Timothy O’Hanlon 1999). Essentially, then, the current assistance system is viewed by its users as a form of insurance, while it is not distributed or financed as insurance.

Conclusion

While expanding coverage to the uninsured improves access and health outcomes, losing coverage worsens health outcomes (N. Lurie, N.B. Ward, M.F. Shapiro, R.H. Brook 1984; Stephen D. Fihn and John B. Wicher 1988). This fact should worry states that recently threatened to cut subsidies to adoptive families (North American Council on Adoptable Children 2003; Erik Eckholm 2005). Oregon attempted a 7.5% across-the-board cut in subsidies, which was contested by adoptive parents (*A.S.W. v. Oregon* (also known as *A.S.W. v. Mink*), 424 F. 3d 970 9th Cir. 2005). Missouri’s attempt to institute means testing for receipt of the adoption subsidy was also contested by parents (*E.C. v. Blunt* (05-0726-CV-W-SOW)). South Carolina reduced its reimbursement for up-front expenses such as legal fees by \$1250 per child. Oklahoma tightened its definition of special needs and reduced post-adoption support for future adoptions. Delaware withdrew support for some psychological and medical treatments not otherwise covered by insurance. Kansas also made selected cuts.

Not only is reducing post-adoption assistance likely to worsen the outcomes for the adopted, but it is likely to discourage families from offering permanent, adoptive families to children who

cannot be reunited with their families of origin. Since adoption improves outcomes compared to foster care—presumably because of the importance of permanence—reducing benefits to adoptive families is likely to injure many children in substitute care. It is therefore likely to make us all worse off.

As has been persuasively argued by Jacob Hacker (2006) and Lael Brainard (2007), the entire economy would benefit from ensuring families against the risks of the modern workplace. These scholars argue that insuring families against unlucky economic outcomes increases their incentive to invest in both general and firm-specific human capital, in addition to increasing entrepreneurial spirit. Since investments in people have large positive externalities—greater investment in human capital improves the lives all by increasing productivity and growth—there is an important role for government in providing this insurance.

To encourage more families to take on the risk of caring for the children in foster care, Title IV-E should be reframed as insurance to guarantee investment in the most vulnerable of our children. As Nancy Folbre (2001, 87) argues: “Reducing the burden of economic pressure on family relationships can improve the quality of emotional interactions.” Nowhere is the quality of emotional interaction more critical than in the life of a child like Jenny who has suffered traumatic loss, abuse, or neglect

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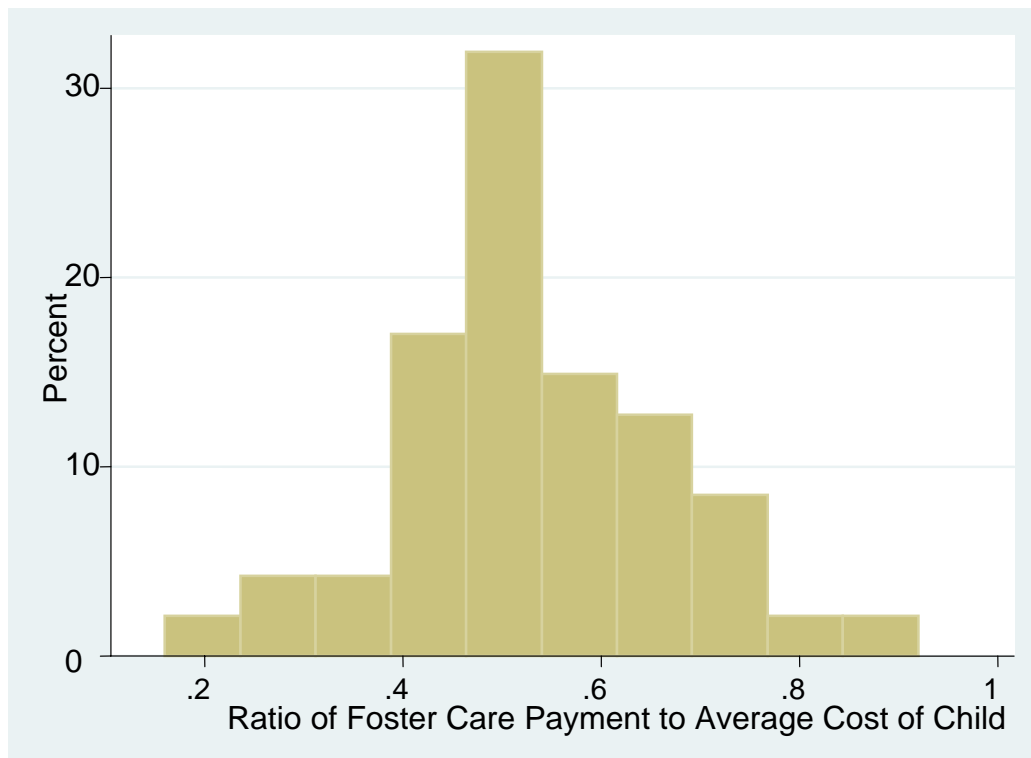
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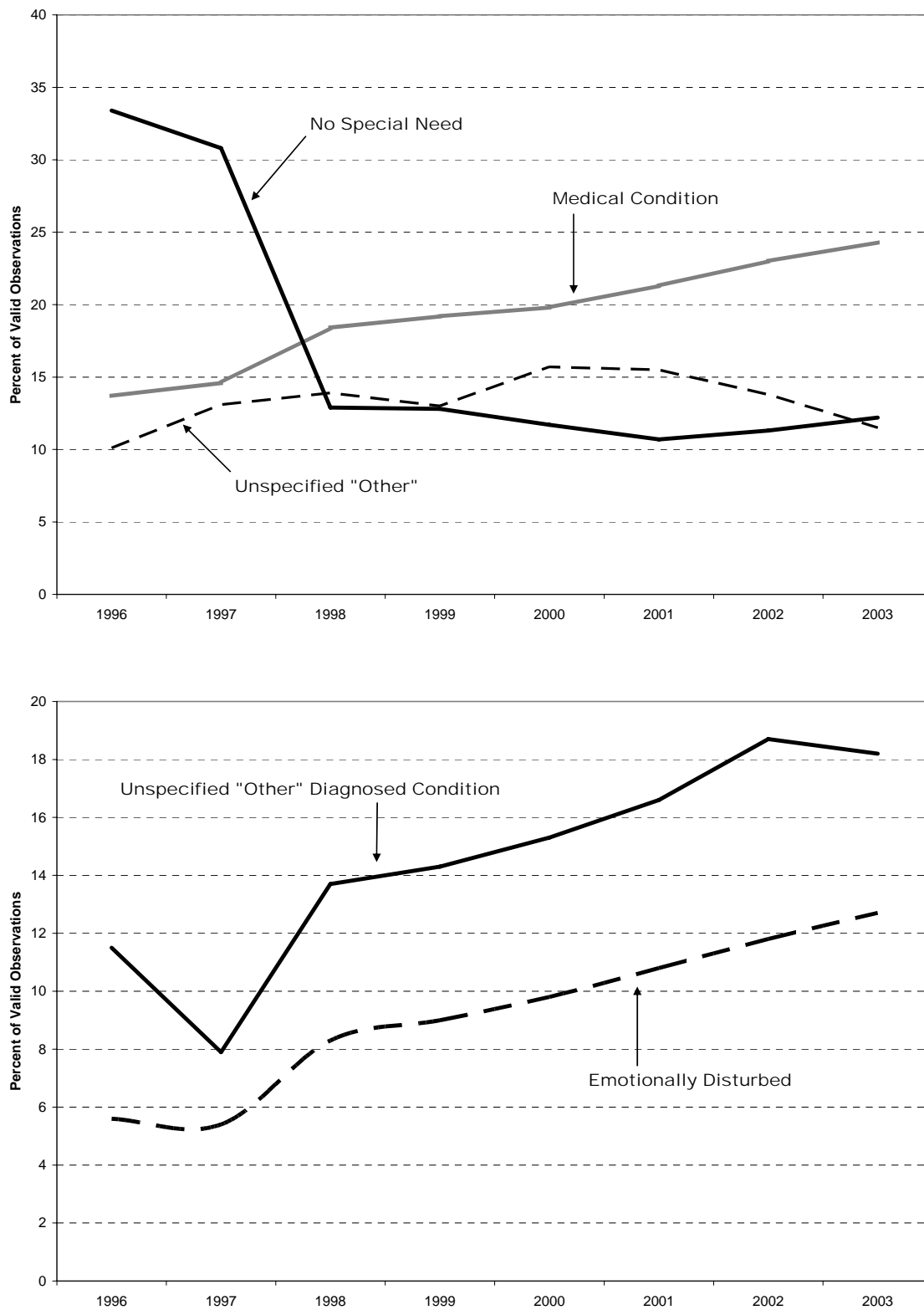
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Figure 1. Distribution of Foster Care Maintenance Payment to Average Cost of Child in the States



Sources: National Resource Center for Family Centered Practice and Permanency Planning (2006) and USDA (2005).

Figure 2. Special Needs of Adopted Children



Source: Computation of author from AFCARS public use adoption data.