Chapter 1

LESSONS LEARNED AND THE WAY FORWARD

Nancy S. Dickinson and Richard P. Barth

The Children's Bureau began in 1912 as the first government agency in the world to focus solely on the problems of children and the first one in this country to be headed by a woman, years before women were allowed to vote. Among the Children's Bureau's many hard-fought battles and significant accomplishments, this chapter focuses on efforts that, in our opinion, require a renewed commitment by the bureau—child mortality, children's well-being, and rigorous research—and their implications for social work practice and education. The chapter calls attention to lessons from the past, which inform prospects for effective 21st century reforms.

Lessons from the Past

Child Mortality

As the first woman to head a federal agency, Julia Lathrop began her tenure as chief of the Children's Bureau in June 1912. The act establishing the Children's Bureau, in the Department of Commerce and Labor, mandated that it "investigate and report . . . upon all matters pertaining to the welfare of children and child life among all classes of our people" (Abbott, 1923, p. 190). With a broad mandate but limited funds—and the political savvy to choose her focus wisely—Julia Lathrop selected, as her first subject of investigation, the least controversial topic: infant mortality. This issue connected with families everywhere in the country and had the virtue of building on existing public interest. The U.S. Public Health Service had previously conducted limited studies of such contributors to infant mortality as contaminated milk but had not pursued more in-depth studies of why infants died (Lindenmeyer, 1995), leaving the way open for Lathrop's focus on the causes and prevention of infant mortality.

Only eight states in 1912 registered live births. Based on these limited data, the Children's Bureau estimated an infant mortality rate of 124 deaths per 1,000 live births (Bradbury, 1962). This placed the United States behind seven other countries that were then measuring infant mortality: New Zealand, Norway, Ireland, Sweden, Australia, Bulgaria, and Scotland (Phelps, 1908). The U.S. rate is currently down to six deaths per 1,000, but that places this country behind 33 other countries, according to the United Nations Population Division (2011). Many of these other industrialized countries took a different approach to dealing with infant mortality, implementing social remedies such as national health insurance, generous maternity benefits, and children's allowances.

As a protégé of Jane Addams of Hull House, Lathrop used a settlement house strategy to fight infant mortality that involved research, outreach, intervention, and political advocacy (Kemp, Almgren, Gilchrist, & Elsinger, 2001). The staff first concentrated their study of infant mortality in Johnstown, Pennsylvania, on 1,919 babies born during 1911. Of those babies' mothers, 81 percent were successfully interviewed about family, social, industrial, and civic factors pertaining to the baby's birth and, in some cases, death. Questions focused on income, ethnicity, mothers' maternal histories and ages, and environmental conditions (Lindenmeyer, 1995).

The Children's Bureau's Johnstown study (and subsequent field studies at seven other sites) documented factors related to infant mortality and showed the correlation between infant mortality and income, poor housing, and inadequate sanitation—demonstrating that poverty was as much a cause of babies' deaths as was poor health care. While the Bureau endorsed the position that high infant mortality could be lowered by community action to help eliminate poverty (Lindenmeyer, 1995), its political solution was to ignore its own research results and focus on maternal behavior rather than societal responsibilities. A series of instructional pamphlets on prenatal and infant care promoted a middle class approach to infant care and offered few solutions for helping poor families escape poverty. It could be argued that the country has continued to ignore poverty's impact on infant mortality.

Nonetheless, the Bureau's first pamphlet, *Infant Care*, became the federal government's best-selling publication, with over 12 million copies distributed between 1914 and 1940 (Kemp et al., 2001). Moreover, the Bureau's study of infant mortality supported progressive reform efforts that contributed to a significant decline in infant mortality rates, so that between 1912 and 1930, the national infant mortality rate was cut nearly in half, from 122 deaths per 1,000 births in 1910 to 66 per 1,000 by 1930 (Kemp et al., 2001).

The bureau's infant mortality research was key to the November 1921 passage of the Sheppard-Towner Maternity and Infancy Protection Act (1921). Considered one of Lathrop's greatest advocacy successes, the act extended matching funds from the Children's Bureau to states for maternal and child health promotion programs. States were encouraged to develop maternal and child health clinics, as well as to reach out to and educate more women in rural areas (Kemp et al., 2001). Because of opposition by the

American Medical Association, however, the act was allowed to lapse in 1929, ending the Children's Bureau's 15-year fight against infant mortality.

The bureau's legacy in the fight against infant mortality was also that of the emerging social work profession. As noted by Almgren, Kemp, and Eisinger (2000), "No single effort by the social work profession in the general domain of prevention has paralleled, in scope or popular support, the campaign to reduce infant mortality undertaken by the U.S. Children's Bureau between 1912 and 1930" (p. 1).

Promoting Children's Well-Being

These prevention efforts helped to increase the credibility of the Children's Bureau and allowed Lathrop to begin working on other projects, including advocating for playgrounds, establishing visiting nurse systems, promoting the registration of births, and opposing child labor. Childhood as a time of play and innocence was predominately a middle-class notion during this period; many poor children worked outside the home, in factories or elsewhere, receiving low wages and lacking access to education. The 1900 U.S. Census showed that one in six youths between 10 and 15 years of age was employed (Children's Bureau Express, 2011). Despite hard-fought efforts to eliminate child labor, the Children's Bureau was only successful in 1938 when the high adult unemployment rates changed political and legal attitudes toward child labor regulation (Lindenmeyer, 2011).

The early Children's Bureau did not officially look into issues of abuse or neglect. Lathrop's position, influenced by her work at Hull House, was that the brutal working conditions and terrible economic problems of the parents caused their abusive and neglectful behaviors (Tichi, 2007). She did not see that some parents abused their children because of factors unrelated to purely economic stress.

By the 1930s, much of the Children's Bureau's focus shifted to children's health. Title V of the 1935 Social Security Act provided states with maternal and child welfare grants, which were used to pay for physicians, dentists, medical social workers, and nutritionists, as well as home visits by public health nurses. These programs reached a racially and ethnically diverse population. "Thus the Children's Bureau provided pathbreaking ways of improving the health of historically underserved groups" (Helfand, Lazarus, & Theerman, 2000, p. 1703). The Social Security Act also enabled the Children's Bureau to support state and local child welfare services "for the protection and care of homeless, dependent, and neglected children, and children in danger of becoming delinquent" (Social Security Act, 1935, ch. 531, title V, § 521, 49 Stat. 633).

In 1946 the Children's Bureau was transferred to the Social Security Administration by an executive order of President Truman, which predicted that the transfer "will strengthen the child-care programs by bringing them in closer association with the health, welfare, and educational activities with which they are inextricably bound up"

(Social Security Online, n.d.). This move demonstrated the bureau's change in focus from infant mortality and child labor to other pressing child health and welfare issues.

By 1969, political and professional pressures caused most of the maternal and children's health programs to be moved out of the Children's Bureau to other parts of the Department of Health, Education, and Welfare, where the Bureau had moved in 1953. In the 1950s and 1960s, the Bureau also lost control of the mental health, child development, child care, and juvenile delinquency initiatives to other newly created departments (Parker, 1994) and focused more narrowly on child abuse and neglect.

During the 1960s and 1970s, there was an unprecedented expansion of government-supported child protection and foster care services. Increased public focus on child abuse and neglect (for example, Kempe, Silverman, Steele, Droegemueller, & Silver, 1962) turned the attention of the Children's Bureau to this issue. The government, rather than private or religious charitable groups, became the primary provider of these services (Davidson, 2008). Creating a federal research and policy framework for this work became essential and evolved into the central focus of the Children's Bureau. The Child Abuse Prevention and Treatment Act of 1974 (P.L. 93-247) became the first of three major child welfare policies passed from 1974 to 1980 for which the Bureau had implementation responsibilities; the other two were the Indian Child Welfare Act of 1978 (P.L. 95-608) and the Adoption Assistance and Child Welfare Act of 1980 (P.L. 96-272). The Child Abuse Prevention and Treatment Act is discussed in the section on prevention below and in more detail in chapter 7.

Research as a Driver of Practical Reform

From the beginning of the Children's Bureau, Julia Lathrop modeled her belief that research could buttress reform (Machtinger, 1999), a view she honed while she was the first head of the research department at the Chicago School of Civics and Philanthropy (later the School of Social Service Administration and one of the country's first schools of social work). Lathrop oversaw all research activities by the Bureau (Rodems, Shaefer, & Ybarra, 2011). In the infant mortality campaign, the Children's Bureau staff practiced on a national scale the integrated prevention strategies—applied research, multilevel outreach and intervention, and political advocacy—that they had learned and tested in the urban settlement houses (Kemp et al., 2001). In 1917 Lathrop initiated the Children's Bureau practice of collaborating with universities when she contracted with the Chicago School to do research on mothers' pensions (Machtinger, 1999).

Between 1912 and 1921, 46 evidence-informed documents on child and maternal health were published by the Children's Bureau, ranging from short pamphlets on care of infants and young children to reports on comprehensive field studies covering such subjects as state and federal infant health policies and visiting nurse programs (Rodems et al., 2011). In 1924 the Children's Bureau, in partnership with the Yale School of Medicine and the New Haven (Connecticut) Department of Health, conducted field research focused on the incidence and prevention of rickets in New Haven (Children's Bureau, 2012), a forerunner of the multidisciplinary research efforts supported by the Bureau today.

The methodological rigor of the field studies contributed to social science and social work scholarship. For example, in her field research on infant mortality, Lathrop was effective in using a cohort approach in which a birth cohort of infants was followed for a one-year period, a method that became standard in epidemiologic studies (Rodems et al., 2011) and, increasingly, child welfare studies (for example, Putnam-Hornstein, 2011).

The Children's Bureau also conducted cross-national comparisons of infant mortality and maternal health care, drawing attention to the fundamental role of government in other countries' support of maternal and child health and suggesting it as a model for the United States (Rodems et al., 2011). In 1917 the Bureau published a report on efforts in small towns and rural districts in New Zealand that produced low rates of infant mortality through the use of nurses who educated parents in their homes on infant care and home hygiene (Rodems et al., 2011). Now compiled by the United Nations (which was not established until nearly 30 years later) rather than the Children's Bureau, the international comparative listings of infant mortality rates have become a public health staple and now include 194 countries.

Research during the 1930s focused primarily on the effects of unemployment on families and children (Children's Bureau, 2012). In addition to looking at the living conditions of adolescents who were roaming the country and at the effects of the economy on families of railway workers, the Bureau compiled monthly national relief statistics from all U.S. cities with populations of 50,000 or more.

Children's Bureau researchers were not only interested in the epidemiology of health problems, but also studied the development of antisocial behavior. They studied the causes of juvenile delinquency during World Wars I and II and in 1927 began recording standardized juvenile court statistics on delinquency, dependency, and neglect (Children's Bureau, 2012).

Social Work and the Children's Bureau

Schools of social work were beginning to appear around the time the Children's Bureau was established. In 1904 the New York School of Applied Philanthropy (later the Columbia University School of Social Work) began as the country's first higher education program to train people in social work, including child development and youth work. As previously noted, the Chicago School of Civics and Philanthropy (later the School of Social Service Administration) was another early school of social work, opening its doors in 1908 and focusing on social science and social research.

Social Workers Lead the Children's Bureau. The first federal agency focused on children was headed by women whose careers were embedded in the settlement house movement and informed by schools of social work. As noted previously, Julia Lathrop, the first director of the Children's Bureau (1912–1921), lived and worked at Hull House and taught research at the Chicago School of Civics and Philanthropy.

The second director of the Children's Bureau, Grace Abbott, was also a resident at Hull House in 1908 and taught at the Chicago School of Civics and Philanthropy, where her sister, Edith Abbott, later became the dean of the newly created University of Chicago School of Social Service Administration in 1924, the first female dean of any graduate school in the country (School of Social Service Administration, University of Chicago, n.d.). Grace Abbott's greatest contribution to the Children's Bureau was helping to draft Title V of the Social Security Act, which included child welfare, services to children with disabilities, and maternal and child health provisions (Parker, 1994). After 13 exceptionally productive years as director, Grace Abbott resigned because of poor health.

In 1934, Katharine Lenroot assumed the bureau's helm, strongly supported by social workers connected to the New York School of Applied Philanthropy. Lenroot was thought to be an adequate administrator but to lack a vision for the future of the Bureau, a view shared by another social worker in the government, Harry Hopkins (Parker, 1994). Hopkins did not feel that Lenroot could successfully administer the program established under Title IV of the Social Security Act, Aid to Dependent Children, and so intervened to have a new agency, the Bureau of Public Assistance, assume responsibility for that program. At that point, the Children's Bureau lost an opportunity to support an integrated approach to serving families (Parker, 1994). Lenroot had more success in the international arena, creating the United Nations International Children's Emergency Fund (UNICEF), representing the United States at four Pan-American Child Congresses, and serving on the executive board of UNICEF from 1947 to 1951 (Children's Bureau, 2012).

Martha Eliot, a medical doctor, worked at the Children's Bureau as assistant and then associate chief to administer health-related Title V grants to states (Parker, 1994). Eliot was director of the Children's Bureau from 1952 to 1956. Among her accomplishments were helping to draft the child welfare portions of the Social Security Act and conceiving and implementing the Emergency Maternity and Infant Care program (Children's Bureau, 2012).

Katherine Oettinger was the next director of the Children's Bureau, the first who was formally trained as a social worker and a former dean of the Boston University School of Social Work. During her tenure (1957–1968), Oettinger presided over a sixfold increase in the Bureau's budget and was instrumental in focusing public attention on child abuse and neglect, child care, programs for children with disabilities and juvenile delinquency (Children's Bureau, 2012).

Social Work Plays a Central Role in Child Welfare. The rise in professional social work paralleled the beginning of the Children's Bureau and played an early role in the use of social casework in mothers' pensions programs between 1912 and 1930 (Machtinger, 1999). During Julia Lathrop's tenure at the Children's Bureau, there was strong advocacy for public provision of pensions to single mothers who had lost husbands to death, desertion, or imprisonment. Before becoming chief of the Children's Bureau, Lathrop had a prominent role in developing a mothers' pensions policy in Illinois. Her advocacy on this issue was based on her reading of the evidence that long-term public support for single mothers would help to eradicate female poverty, which contributed to infant mortality, and ease the burden of mothering and working for low wages (Machtinger, 1999). These settlement house reformers believed that poverty resulted not from personal shortcomings but from structural causes such as unemployment and low wages, and they advocated for state and federal governments to intervene to provide essential support for mothers and children.

Lathrop brought these convictions and policy successes into play at the Children's Bureau, where she advocated successfully for development of mothers' pensions laws in states, so that by 1920 there were such laws in 40 states (Machtinger, 1999). Problems with implementation of these laws led the Bureau to collect, analyze, and disseminate information about laws and standards of care of dependent children. Children's Bureau staff also wanted to ensure the quality of services by requiring delivery by trained social workers (Machtinger, 1999). The use of the newly developed social casework method became central to the work with mothers. Through its emphasis on investigation, diagnosis, and treatment, this individualized approach assumed social pathology on the part of recipients. It can be said that the use of social casework practice turned the focus of the mothers' pensions away from societal reform as necessary for the eradication of poverty, which the settlement house reformers had emphasized. As Machtinger (1999) stated, the social casework approach focused more on improving the individual mother and "was a step away from the bureau's original focus on mothers' pensions as a social and economic right" (p. 115).

Children's Bureau Plays a Lead Role in Social Work Education. With leadership from the Children's Bureau, agencies and universities collaborated to make social work education available to those wanting a career in child welfare (Ellett & Leighninger, 2007). Other chapters in this book discuss this collaboration in far more detail. This section summarizes policies that have supported these collaborations. The federal government began providing grants to states for child welfare in 1935 through the Child Welfare Services Program, Title IV-B of the Social Security Act (Child Welfare Information Gateway, 2011), and states were encouraged to use this funding to support educational leave for staff members seeking a social work degree. In 1962 the Title IV-B, Section 426 Discretionary Training Grant Program was created to provide financial support for social work education.

Since passage of the Adoption Assistance and Child Welfare Act of 1980 (P.L. 96-272), and more frequently since 1990, states have used Title IV-E funding to enable public universities to provide stipends for BSW and MSW education. There has also been a significant growth in IV-E-funded training academies that prepare child welfare workers for their roles. The country has, arguably, never had so many child welfare workers with specialized educational preparation and high-quality preservice training.

Despite this progress, there is no continuity across states in educational requirements for child welfare staff and no national data about educational backgrounds of current employees. Even counties within states vary in what they require—a substantial number of them now prefer a MSW for every child welfare worker, and many more require a MSW for every supervisor. These requirements are supported by research, which has shown that a social work degree, with an emphasis on child welfare practice, is a strong contributor to child welfare worker retention and improved worker competence (Fox, Miller, & Barbee, 2003; Jones & Okamura, 2000).

Prospects for Twenty-First Century Reforms: Policies, Programs, and Workforce Development

This chapter's first section dealt with selected issues and themes from the early decades of the Children's Bureau: child mortality and well-being, research, and the social work profession and practice. This section describes how these early themes were the seeds for 21st century reforms that we believe merit renewed attention. Topics discussed in this section are child abuse prevention (with an emphasis on preventing maltreatment fatalities), intervention research, and social work practice and education.

Child Abuse Prevention

Efforts by the Children's Bureau to prevent child abuse have increased in focus and intensity since the early 1960s. This section draws attention to policies and programs that are proving beneficial for preventing maltreatment fatalities, as well as physical and sexual abuse.

Maltreatment Fatalities. As described earlier, the Children's Bureau's first task was to study and work to prevent infant mortality, which was largely attributable to poverty, poor living conditions, and lack of health care. While infant mortality rates did decrease over time, concern has lately turned more specifically to fatalities resulting from abuse or neglect by a parent or a primary caregiver. Chapter 8 describes efforts over the last two decades to identify, count, and respond to fatal maltreatment.

Despite child protection programs, child maltreatment fatalities remain a serious problem, with an estimated 1,560 deaths a year, which translates to a rate of 2.07 deaths per 100,000 children and an average of four children—chiefly infants and toddlers—dying every day from abuse or neglect (Child Welfare Information Gateway, 2012). In the last few years, a growing number of states have been able to link birth records, child welfare services data, and mortality records to begin to develop a clearer picture of child mortality risk related to child maltreatment. Putnam-Hornstein (2011) has, for example, demonstrated that children in California who have ever had any contact (substantiated or not) with child welfare services have a five times greater likelihood of dying before the age of five than children in the general population. Such findings may help bring a public health perspective back to child welfare services.

Child Maltreatment Prevention. When addressing the issue of child maltreatment fatalities, prevention is a recurring theme. For example, the child fatality review process helps to identify risk factors, which is useful in developing strategies to prevent future fatalities.

In 1962 Henry Kempe coined the term "battered child syndrome" to describe children's physical and emotional trauma at the hands of family members and caretakers (Kempe et al., 1962). Between 1963 and 1967, all states and the District of Columbia passed child abuse reporting laws, and the Child Abuse Prevention and Treatment Act was passed in 1974. The act provided assistance to states, which developed their own definitions of child abuse and neglect; it was not until its reauthorization in 1996 that a minimum definition of child abuse was set for all states to follow (Child Welfare Information Gateway, 2009). This delay created some problems, which are discussed in more detail in chapter 7.

As a result of these policy efforts, the 1980s witnessed a significant expansion in public awareness of child maltreatment and the development and dissemination of both interventions and prevention strategies, with efforts to prevent sexual abuse diverging from efforts to prevent physical abuse and neglect (Daro, 1988). Most of the modest improvements reported in the 2006 Fourth Federal National Incidence Study on Child Maltreatment (Sedlak et al., 2010) were declines in sexual abuse. According to Daro (2010), these declines could be attributable to sexual abuse prevention efforts in schools, in youth-serving and religious organizations, and through broadly disseminated public safety messages designed to educate children and the general public that sexual abuse is unacceptable. Additionally, cases of sexual abuse are often aggressively prosecuted, with extended incarceration of offenders, and this could be having an effect (Daro, 2010).

Preventing physical child abuse and neglect, on the other hand, has been difficult. Recent prevention efforts focus on supporting parents during pregnancy and at birth, a key period for strengthening the parent-child relationship, which is essential to a child's healthy physical and emotional development. Prevention programs have usually included intensive home-based interventions, such as home visiting programs, but data show that these efforts have not brought about hoped-for results (Daro, 2010). Expanding these intensive services is imperative, and the Patient Protection and Affordable Care Act of 2010 (P.L. 111-148) is set to provide states $1.5 billion through 2016 to expand the provision of evidence-based home visitation programs to at-risk pregnant women and newborns (Child Welfare Information Gateway, 2011). These targeted programs may not be as effective as needed by the most challenged populations—those struggling with serious mental illness, domestic violence, and substance abuse, as well as those living in violent and chaotic neighborhoods. Prevention efforts that should be part of home visitation services include the following (Child Welfare Information Gateway, 2011; Daro, 2010):

- public awareness messages regarding child physical abuse and neglect that target specific parental behaviors that need to change (similar to successful past campaigns targeting sexual abuse)
- education efforts about abuse and neglect targeting all new parents, similar to the educational campaigns regarding "Back to Sleep" and shaken baby syndrome
- universal assessment of all new parents and linking of families with services according to their needs
- evidence-based parent education programs that teach positive parent–child interaction skills appropriate to the child's developmental level and that include skills demonstrations and practice
- child welfare systems with the capacity to work with parents who require mandatory intervention to ensure the safety of children, with staff who are willing to remove children from harm when parents are not willing or able to change

Future efforts by the Children's Bureau to advance prevention should include expanding current strategies that work, funding research to develop new strategies, and supporting the development of strategic partnerships for collective impact across communities (for example, Kania & Kramer, 2011). Challenges include the following (Child Welfare Information Gateway, 2011; see also Dubowitz, Feigelman, Lane, & Kim, 2009):

- improving the ability to reach all populations at risk, both those with severe and chronic challenges and those needing help on an emergency basis
- determining the best interventions for diverse ethnic and cultural groups
- identifying ways to use technology to expand contact and improve service access
- working with the expanding primary care workforce—under the Patient Protection and Affordable Care Act (2010)—to realize its potential for child abuse prevention

Research

As noted earlier, Julia Lathrop brought to the Children's Bureau her experience as head of the research department at the school now known as the University of Chicago's School of Social Service Administration. Lathrop personally oversaw all research activities at the Bureau and developed contracts with universities for specific research activities. Epidemiological research on infant mortality, rickets, juvenile delinquency, and other topics became a standard method for research at the Children's Bureau. Cohort analysis was a staple of this work as well.

State and National Data Collection, Analysis, and Reporting. Epidemiological research occurs today in the collection, analysis, and reporting of data on adoption and foster care, child abuse and neglect, and child welfare. Authorized in 1984, the Adoption and Foster Care Analysis and Reporting System collects and reports case-level information on all children in foster care and on children who are adopted under the auspices of the state's public child welfare agency. By 1993, the Children's Bureau was providing states with the opportunity to obtain 75 percent federal funding to plan, design, develop, and implement the automation systems needed to collect data on foster care and adoption. It has also provided support, beginning in the 1990s, for a National Resource Center on Child Welfare Data and Technology to assist states with their information technology needs. The Bureau has also developed an assessment review process to help states identify and solve problems with their automated information systems.

The National Child Abuse and Neglect Data System, a data collection and analysis system, was created in response to the requirements of the Child Abuse Prevention, Adoption, and Family Services Act of 1988 (P. L. 100-294), which authorized limited government research about child abuse prevention and treatment. In addition, the act created the National Clearinghouse on Child Abuse and Neglect Information and the National Center on Child Abuse and Neglect, which was charged with identifying issues and areas needing special focus in new research and demonstration projects (Child Welfare Information Gateway, 2009).

The act also broadened the scope of research to include the National Incidence Study of Child Abuse and Neglect, which started with much difficulty and has now been carried out four times. Early studies estimated overall incidence of moderate and severe child maltreatment. The latest (fourth) study had enough statistical power and measurement precision to test key hypotheses about populations at greatest risk for maltreatment (Sedlak et al., 2010).

Strengthening Research Infrastructure. In the early 1990s the Children's Bureau invested in strengthening the field's research infrastructure. Funding three National Child Welfare Research Centers for five years, the Bureau endeavored to develop research programs that could inspire child welfare researchers and provide instruction on research methods. Chapin Hall Center for Children at the University of Chicago began an ongoing summer administrative data analytics institute, and the University of California, Berkeley's Child Welfare Fellows Institute brought aspiring child welfare scholars in to learn about analysis of administrative data and other research matters.

Data from the Adoption and Foster Care Analysis and Reporting System and National Child Abuse and Neglect Data System are now drawn on to construct the annual Child

Welfare Outcomes report to Congress. The National Youth in Transition Database collects case-level information on youth currently in foster care and those who have aged out of care. In 1999, the Children's Bureau began the Child and Family Services Review, a process for assessing states' performance on seven outcomes and seven systemic factors supporting the achievement of outcomes related to safety, permanency, and well-being. This review system represents a departure from compliance-driven reviews under Titles IV-B and IV-E of the Social Security Act, which primarily ensured states' conformity to policies and procedures. The Child and Family Services Review makes it possible for states to learn important lessons from administrative data and, through a review of a small sample of cases, to understand service processes and outcomes for children, youths, and families.

Research funded by the Children's Bureau in collaboration with other federal offices and institutes includes the Longitudinal Study of Child Abuse and Neglect, on the causes and impact of child abuse and neglect, initiated in 1990 with grants from the National Center on Child Abuse and Neglect and composed of five collaborating longitudinal research projects. More recently, the National Survey of Child and Adolescent Well-Being has collected data that describe the child welfare system and the experiences of children and families who come in contact with it. Although managed by the Office of Planning, Research, and Evaluation, the National Survey of Child and Adolescent Well-Being follows the tradition of the Children's Bureau by tracking the life course of children to gather data about services received, measures of child well-being, and longer term results, information that will provide a clearer understanding of life outcomes for children and families involved with the child welfare system.

Promoting Investigator-Initiated Research. A possible negative consequence of funding these larger projects (especially the National Incidence Study and the National Survey of Child and Adolescent Well-Being) has been the contemporaneous decrease in field-initiated research by child welfare scholars. In contrast, the National Institutes of Health and the Institute of Education Science offer health and education scholars opportunities to apply for grants that reward innovative and rigorous research proposals through a peer-review grants mechanism. Strong proposals can be resubmitted, following painstaking and informative peer review, for reconsideration. No such mechanism for field-initiated research exists for child welfare scholars. Most Children's Bureau grant announcements are very narrowly defined, which arguably places significant limits on research.

Funding Intervention Research. In 2008, the Children's Bureau began awarding five-year cooperative agreements for Quality Improvement Centers to promote knowledge development to improve child welfare services in five areas of focus: nonresident fathers, privatization, differential response, early childhood, and the representation of children. Each Quality Improvement Center conducts a national needs assessment and gap analysis on its area of focus and funds demonstration projects to address identified gaps (Children's Bureau, 2012).

Unlike the historical approach of the Children's Bureau to collecting data for reports and general information, Quality Improvement Center demonstration projects are funded to develop robust evidence about specific interventions. This emerging research strategy is also evident in the recent funding announcements related to trauma-informed practice, permanency innovation initiatives, home visiting, and IV-E waiver demonstration projects, among others.

Evidence-Based Practices

The early leaders of the Children's Bureau promoted the use of research evidence to inform the bureau's practices and programs. They were committed to linking research to practice to improve the lives of infants and new mothers, homeless and delinquent children, and those with physical illnesses. That commitment to designing, implementing, and evaluating promising programs and practices to improve outcomes for children, youth, and families lost strength toward the end of the 20th century but appears to be gaining new impetus as the Children's Bureau enters its second century. Intervention testing and implementation tools that bring evidence to bear on outcomes are more available and effective than before. Whether they will have enduring use depends on the commitment of the child welfare system to creating evidence-based child welfare practices and ensuring their use.

Evidence-based practice (EBP) is a fairly new concept in child welfare, compared with fields such as medicine, public health, and mental health, which began broader discussions of EBP in the early 1990s. The California Evidence-Based Clearinghouse for Child Welfare (n.d.), one of several organizations that review and screen evidence-based interventions, defines evidence-based child welfare practice as based on a combination of best research evidence, best clinical experience, and consistency with family and client values. Identifying practices that are supported by strong scientific research ensures that the best possible interventions are available for use with child welfare populations.

The number of EBPs for child welfare is increasing, but slowly. On the Clearinghouse list, for example, 108 practices have a high child welfare relevance rating (possible ratings are high, medium, and low). Each practice listed by the Clearinghouse has been rated as (1) well supported by research evidence, (2) supported by research evidence, (3) having promising research evidence, (4) failing to demonstrate effect, (5) being a concerning practice, or (NR) not able to be rated. Searching the Clearinghouse for the highest scientific rating resulted in a list of 21 EBPs. Yet only two programs receive the highest rating for both level of evidence and child welfare relevance: Project SUPPORT, an in-home parenting education program for mothers who have left domestic violence shelters, and trauma-focused cognitive–behavioral therapy.

Implementing EBPs requires commitment and a host of supports, including expert practitioners to deliver or facilitate them, skilled supervisors to provide training and ongoing support, leadership to help overcome inertia and attachment to existing procedures, an organizational climate that encourages innovation, and adequate financial resources to build the necessary infrastructure. Once implemented, at least some EBPs have been highly endorsed by child welfare service providers (Aarons, Sommerfeld, Hecht, Silovsky, & Chaffin, 2009). When combined with experienced, intensive supervision, they help agencies to reduce the variability in the achievement of favorable outcomes so that families with greater problems are more likely to benefit (Chaffin, Hecht, Bard, Silovsky, & Beasley, 2012).

Child welfare agencies are beginning to demonstrate greater integration of some evidence-based parenting programs like Parent Child Interaction Therapy and SafeCare. Yet there is a long way to go before agencies routinely require and fund these interventions rather than training programs that are less intensive, do not have structured parenting practice, and are led by people without adequate training or coaching (Barth et al., 2005). The opportunity to increase the use of parenting programs and interventions to reduce the impact of trauma are two of the most promising additions to child welfare services. Far less developed are EBPs for reunification, case management, and post-adoption services.

Beyond the scope of this chapter is a discussion of the funding, organizational, community, professional, and practice challenges related to implementation of EBPs, as well as the role of the child welfare workforce in implementing EBPs. What should child welfare workers in different positions be able to do? Should they be able to assess which children need access to an EBP, refer children to the correct EBP based on assessment data they collect, ensure that contract workers are delivering an EBP, or deliver the EBP themselves? In order to be able to take any or all of these steps, child welfare workers must have knowledge about EBPs and the skills, motivation, and time to make appropriate referrals to them. Much has been learned about teaching EBPs so that they are used by the practitioners who learn them, but little is known about how to arrange for referrals to them (Barth, 2008).

Implications of Evidence-Based Practices for Social Work Education

Education of social workers on child welfare practice is beginning to adapt EBPs. A growing expertise in motivational interviewing, for example, is emerging. An innovative approach that engages the developers of EBPs in the training and ongoing coaching of field instructors and of MSW students has been tested in a cluster of schools of social work. This approach is reducing the gap between what is taught in the classroom and what is known by field instructors, and vice versa.

If given the chance, EBP can become a unifying framework for social work education, as it integrates cultural responsiveness, ethics, research, practice theory, skills, and macro and micro perspectives (Drake, Hovmand, Jonson-Reid, & Zayas, 2007). The response of social work programs—and the Children's Bureau—must be a commitment to preparing expert child welfare professionals (perhaps through a three-year MSW program), funding doctoral and postdoctoral child welfare research, and supporting social work faculty in developing evidence-based child welfare interventions.

Using Lessons Learned to Improve Prospects for Reform

In their article promoting a study of the past to reveal "good ideas that still deserve to be acted upon," Golden and Markel (2007, p. 445) assert that the founding of the Children's Bureau inspired hope that children would be in the forefront of U.S. domestic policy. That hope was energized by the passage of the Sheppard-Towner Maternity and Infancy Protection Act (1921), as a result of which more than 4 million infants and preschool children and approximately 700,000 pregnant women were served through state programs through 1929 (Lindenmeyer, 1995).

Following that achievement, as discussed earlier, the Children's Bureau's political compromises and loss of power resulted in a splintering of efforts to focus on the "whole child" (Kemp et al., 2001). The telling result of these political and professional setbacks is that today federal programs are organized by function rather than by constituency, so that services for children cut across multiple federal departments. For example, child health programs are under the U.S. Public Health Service and the Health Resources and Services Administration, the U.S. Department of Education oversees state grants for infants and toddlers, the economic well-being of children and families is the purview of the Temporary Assistance for Needy Families program in the U.S. Department of Health and Human Services (HHS), and the Substance Abuse and Mental Health Services Administration has funded women, children, and family treatment programs. This fractured approach to serving children, youth, and families wastes resources, including the financial and political resources required to keep the needs of the "whole child" (and the family) in the forefront of national interest and responsibility.

To counter this fractured approach, Golden and Markel (2007) envision a Department of Children's Affairs, a fully funded Cabinet-level agency responsible for raising standards of health, welfare, and education for children. All government agencies dealing with children, including the Department of Education and all HHS agencies serving children, would be brought under the leadership of the new department.

We propose consideration of an alternative approach that involves creation of a Cabinet-level Director for Children. The Director for Children would also be the director of the Children's Bureau and would have the responsibility to assist all Cabinet members to identify their children's portfolio and to recommend ways that their policies can most advantageously affect children. The Director for Children would also lead meetings of a Children's Cabinet, which would comprise designees from all Cabinet-level agencies who are responsible for children's interests. In leading the Children's Cabinet and participating in the national Cabinet, the Director for Children would assist all federal departments to make policy and program decisions in keeping with a unifying view of protecting children and improving children's outcomes.

However we might bring more attention and resources to bear on behalf of children, what should be certain is the commitment to see that a stronger Children's Bureau returns to its founding mandate to "investigate and report . . . upon all matters pertaining to the welfare of children and child life among all classes of our people" (Abbott, 1923, p. 190). "The achievements of the Children's Bureau in the opening decades of the twentieth century—when it faced political opposition, government infighting, and the economic strictures imposed by the Great Depression—should be regarded as an inspiration" (Golden & Markel, 2007, p. 449). Bringing action to inspiration will involve a lot of hard work. But the prospects for children who are increasingly living in poverty, failing to get a high-quality education, lacking medical care, dying unnecessarily in infancy, and suffering maltreatment are worth the effort.

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