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DOMESTIC ARTICLES:
A FOCUS ON THE SOUTHEAST & SOUTHWEST

Reclaiming the Federal Role in Education

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This paper is adapted from Derek W. Black's papers "Abandoning the Federal Role in Education," 105 *California Law Review* 1309 (2017) and "The Fundamental Right to Education," 94 *Notre Dame Law Review* 1059 (2019).

On most major measures, educational inequality is holding steady or on the rise. Achievement, segregation, and funding data all indicate that poor and minority students are receiving vastly unequal educational opportunities.¹ For instance, predominantly minority schools receive about \$2,000 less per student than predominantly white schools.² Even putting aside this inequality, overall government commitment to public education is receding. Since 2008, most states have substantially decreased school funding, some by more than 20%.³ The federal government has done little to stem the decline. Most disturbing, some states are currently taking steps to amend their state constitutions and make cuts to education even easier.⁴ Parents increasingly doubt that the public education system can weather these challenges and are exiting the system altogether.⁵ In short, public education stands in the midst of practical and constitutional crises.

These crises call for a federal solution in which Congress reestablishes its founding role in assisting and ensuring that states deliver adequate public education to all. While the federal role in education has been increasingly contested in recent decades — and retracted most recently — that role is grounded both in the nation's founding and its later reframing following the Civil War. In other words, the case for the federal role in education is originalist. We can trace the fundamental importance of education from the nation's founding principles through the years immediately following the 14th Amendment.

Most poignantly, in the years surrounding the final ratification of the 14th Amendment, Congress demanded that states guarantee access to public education in their state constitutions and linked these demands to the 14th Amendment itself. Unfortunately, this history has quite simply been overlooked. While the Court's fundamental rights analysis remains unchanged, new historical evidence and insights reveal that, contrary to conventional wisdom, education was originally understood as being part of a "republican form of government," which the constitution guarantees.

The founders held firm beliefs about the necessity of an educated citizenry in a republican form of government,⁶ which is also manifest in the distinct educational practices in the United States as compared with other countries.⁷ Unsurprisingly, then, when Congress reframed the state–federal relationship through the 14th Amendment, Congress acted decisively on those beliefs, demanding education from every state in the nation.⁸ In fact, no state would ever again enter the Union without an education clause in its constitution.

The Framers sought to ensure access to education with a specific end in mind: the preparation of individuals for citizenship in a republican form of government. They did so for three reasons. First, they believed it was the duty of citizens to vote.⁹ Second, effective self-government required educated voters.¹⁰ Third, the government could only demand educated voting if it carried out its duty to ensure citizens access to education.¹¹ Thus, the extension of a right to education was an act of self-preservation by the government and its people.

In the wake of the Civil War and subsequent anti-Black policies in Southern states, Congress responded by passing legislation to address education deprivations and move the South toward a working democracy. Through the Freedman's Bureau,¹² Congress directly expanded educational opportunities throughout the South.¹³ Congress then used the Reconstruction Act of 1867 to force states to include education clauses in their state constitutions.¹⁴ Weeks after passing the Reconstruction Act, Congress would establish a Department of Education, whose practical purpose was to monitor whether states were carrying out their education obligations.¹⁵ The statute indicated the Department would assess "the condition and progress of education in the several States" and "aid" in its further expansion "throughout the country."¹⁶

This history reveals that the right to education is not one that simply evolved due to modern necessities or an expanded federal footprint. Rather, a commitment to education as a fundamental necessity of citizenship was with the nation from the beginning. A substantive standard can be reduced to a single sentence: a fundamental right to education requires the state to provide individuals with the skills to comprehend the political discourse of the day, evaluate its merits, and then act thoughtfully through the ballot and other means of accountability. This originalist argument could, in effect, compel Congress, if not the courts, to safeguard the right to education, not simply because it wants to, but because the framers would have expected it, by demonstrating that public education was a central premise of the very form of government enshrined in the Constitution in 1787.

Reconsidering ESSA

In 2015, Congress passed the Every Student Succeeds Act (ESSA), redefining the role of the federal government in education. ESSA attempts to appease popular sentiment against the No Child Left Behind (NCLB) Act's overreliance on standardized testing and punitive sanctions. However, in overturning those aspects of the NCLB, Congress failed to devise a system that was any better. Congress simply stripped the federal government of regulatory power and vastly expanded state discretion. For the first time in 50 years, the federal government now lacks the ability to make prompt improvements in student achievement or to demand equal resources for low-income students. Thus, ESSA rests on a bold premise: states will abandon their historical tendencies by voluntarily providing low-income students with equal educational opportunities.

Simply repealing ESSA is no more of a realistic option than was repealing NCLB. Unless Congress is willing to eliminate federal funding for schools altogether, some other federal structure must be put in its place.

Congress can realign the Elementary and Secondary Education Act (ESEA) with its historic mission of improving academic achievement and equity for low-income students, but it should also enact better mechanisms to achieve those goals. First, ESEA must increase federal investment in education. An increased federal investment is also necessary if states are to accept the second step: strict prohibitions on the unequal distribution of educational resources by states. The final step is to expand preschool education to all low-income students — a goal the Department of Education has pushed in recent years, but which states seemingly lack the capacity to reach alone. The following sections explore each of these points in full.

A. Increase Federal Investments

The federal financial stake in education should substantially increase and move states toward delivering the full supplemental funding necessary to provide adequate educational opportunities for low-income students. Estimates of the additional resources necessary for low-income students to achieve at levels comparable to their peers range from 30% to 60%.¹⁷ The federal government itself has officially pegged 40% as the appropriate supplement.¹⁸ States are far from meeting this standard.

Skeptics' primary question is why the federal government should take on a larger financial commitment in an area of traditional state concern and control. Or similarly, why not simply demand that states meet appropriate resource goals themselves? The answers to these concerns are threefold. First, some states appear to lack the resources to fund education adequately and equitably.¹⁹ As one study found, the greatest inequities are between states — not within.²⁰

Second, many states with relatively high fiscal capacity have shown very little incentive to equalize education.²¹ These states may fund education at relatively high levels, but funding can be wildly unequal across districts. In other words, a large group of states breaks into two different camps: one with a commitment to equity but no capacity for adequacy, and another with the capacity for adequacy but no commitment to equity. One cannot be realistically achieved without the other.²²

Third, helping low-capacity states necessarily requires federal assistance, and motivating high-capacity states necessarily requires federal leverage. The federal government cannot expect these two goals to be reached without a significant influx of funding. Both involve substantial additional money — enough to make the deal enticing for states. This leaves Congress's power under ESEA. For spending legislation, Congress's only power is to secure states' voluntary consent to conditions in exchange for money.²³ Congress and the President clearly understood this relationship in passing the NCLB. NCLB drastically expanded the federal role in education, but only in exchange for a major increase in federal funding.²⁴ If Congress is to further promote equity and adequacy through ESEA in the future, it must do the same again.

B. Demand Equity Through a Multi-Prong Approach

ESEA should set strict equity requirements but offer states the ability to transition to full equity and the progressive funding outlined above over time. To immediately require absolute resource equality in the context of widespread and deep inequality would create circumstances like those that produced NCLB waivers. The NCLB Act set unrealistic student achievement requirements and included no contingency plan to keep schools on track when they failed to meet them. Restructuring school funding is more realistic than moving all students to full proficiency, but as school finance litigation has shown, restructuring funding is far more politically challenging at the state and local level.²⁵

Title IX of the Education Amendments of 1974 offers a compelling alternate model through which the federal government could consistently and progressively phase states toward equity. At Title IX's passage, females were formally excluded from certain educational institutions and systematically discriminated against in others.²⁶ Over the past four decades, Title IX has eliminated most forms of sex-segregated education and drastically closed opportunity gaps elsewhere.²⁷ For example, in 1971, only 7% of females participated in high school athletics.²⁸ By 2007, more than 40% were participating.²⁹ In raw numbers, this represents a 940% increase in the number of female athletes.³⁰

ESEA could adopt an analogous multi-prong standard that sets fixed requirements of varying difficulty to meet. The first prong would set an absolute requirement that states provide schools serving higher percentages of low-income students with the proportionately larger supplemental resources they require. This standard would apply both within and between school districts. Based on current data, not a single state in the nation would have met this standard on a consistent basis in recent years. Since 2010, only two states — Utah and New Jersey — have hit this mark more than once, and they only hit it twice.³¹ At the other end of the spectrum, roughly half of the states fund high-need districts at lower levels than districts that are predominantly middle income and wealthy.³²

The second equality prong could provide the remaining states interim relief while still pushing them to make progress. Like Title IX's progress standards, states and districts with a history and continuing practice of closing funding gaps and moving toward the required supplemental funding

for high-need schools would be exempted from the absolute equality requirement. Once a state eliminates this raw funding gap, prong two might require that states demonstrate no less than a 2% increase in funding for high-need districts relative to other districts each year. Under this standard, an average state doing the bare minimum would still have 20 years to meet the absolute requirement of the first prong, but like Title IX, it would set a clear and realistic path to reaching the equality goal.

A third prong could provide an entirely distinct metric of equality — one based on academic achievement. States and districts would be allowed to demonstrate that, regardless of resources low-income students receive, their low-income students achieve at reasonable levels representative of equal educational opportunity. A state or districts could make this showing in one of two ways, demonstrating that their low-income students (1) achieved at a level equal to or above the national average for low-income students or (2) made one year's worth of academic progress during the past school year. Both of these showings would be based on the National Assessment of Educational Progress (NAEP), the national benchmark for academic achievement.³³

This third prong would serve several important ends without repeating NCLB's or ESEA's past mistakes. First, it concedes the notion that although resources are the primary criterion of educational opportunity, resources are not an infallible measure. In some circumstances, other measures may be more valid. A prong directed at student achievement also provides some level of continuity with prior federal policy, but its mechanics would work far differently than the NCLB's or ESEA's. On the one hand, this third prong would maintain the relevance of tests, their potentially conclusive effect, and the basic data upon which so much research and analysis rest. On the other hand, relying on NAEP scores would eliminate the possibility of local variation and the incentive to manipulate state tests, both of which can render test results meaningless.³⁴ Similarly, benchmarking low-income students' performance against a national average or a year's worth of progress would eliminate unrealistic achievement goals like those found in NCLB. Instead, these benchmarks would take into account the fact that low-income students as a group are not similarly situated to other students.³⁵

While aggressive, this three-prong approach would also minimize the perception that the federal government is treating states and local authorities unfairly. States and districts that did meet any of the prongs would not be sympathetic victims of federal intrusion.³⁶ To the contrary, they would be prime examples of states and districts that warrant reprimand. They would have received significant additional federal funding but continued to underfinance their schools and produce poor student outcomes. They could not claim that they had distributed federal funds fairly and it did not work. Nor could they claim their students were performing well notwithstanding resources.

In sum, this three-pronged approach to equity manages a careful balance among competing views and practical limitations. It keeps absolute resource equality at the forefront but recognizes that achieving it requires a mutually reinforcing set of interim progress measures. Equally important, the failure of states and districts to meet this three-pronged approach labels them as the villain, not the federal government.

C. Set Aside Funds for Pre-K Education

The federal government must make a substantial investment in pre-kindergarten education for disadvantaged students. If the purpose of ESEA is to ensure supplemental educational opportunities for disadvantaged students, social science uniformly indicates there is no better supplemental opportunity than pre-kindergarten education.³⁷ The findings are so compelling that political support is widespread.

Conclusion

Now more than ever, the federal government must take an active role in education and reassert its historic role in ensuring student access to a public education that prepares them for citizenship. Absent such an education, the nation still falls short of the republican form of government first envisioned by the framers. It is fully within Congress's power to assert that role without resorting to constitutional amendments or new precedent by the Court. Congress can and must substantially increase federal funding for education to secure states' consent to strict new equity standards and meet the outstanding needs of low-income students. Additional federal funding can also finally make preschool for low-income students a reality in order to close achievement gaps, generate cost savings, and make equalizing school funding more feasible.

1. *Education Trust, Funding Gaps* 2015 3, 8 (2015) (finding that nationally, schools with the most low-income students receive \$1,200 less per pupil than schools serving predominantly wealthy students, and schools serving predominantly minority students receive \$2,000 less per pupil); G. Bohrstedt et al., U.S. Dep't of Educ., *School Composition and the Black-White Achievement Gap* 3 (2015) (finding a persistent and large racial achievement gap); Gary Orfield et al., Civil Rights Project/ Proyecto Dercho Civiles, *Brown at 62: School Segregation by Race, Poverty and State* 1, 3 (2016) (indicating the percentage of intensely segregated minority schools has tripled since 1988).
2. *Education Trust*, supra note 1, at 8.
3. Michael Leachman et al., Ctr. on Budget & Pol'y Priorities, *Most States Have Cut School Funding, and Some Continue Cutting* 1 (2016).
4. Constitution Revision Commission of Florida, *A Proposal to Amend Section 1 of Article IX of the State Constitution* (2017), <https://www.flcrrc.gov/Proposals/Commissioner/2017/0045/ProposalText/Filed/PDF>; Tim Carpenter, "Kansas GOP Making Moves to Prepare for April Vote on K-12 Constitutional Amendment," *Topeka Cap. J.*, Dec. 29, 2017. Mississippi and Alabama have previously acted on similarly dubious motivations. Derek W. Black, "Why Schools Still Can't Put Segregation Behind Them," *Salon*, June 19, 2017.
5. In the last decade, voucher and charter school enrollments have doubled nationally. In some states, enrollments have more than quadrupled. See, e.g., *Ind. Dep't of Educ. et al. Program Annual Report: Participation and Payment Data* 6, 22 (June 2015); Fla. Dep't of Educ., *Corporate Tax Credit Scholarship Program: June Quarterly Report* (2009), <https://www.stepupforstudents.org/wp-content/uploads/2015/09/ctc-stats-09-06.pdf>.
6. See, e.g., Kara A. Millonzi, *Education as a Right of National Citizenship Under the Privileges or Immunities Clause of the Fourteenth Amendment*, 81 N.C. L. Rev. 1286 (2003); George Washington, "Eighth Annual Message to Congress" (Dec. 7, 1796), http://avalon.law.yale.edu/18th_century/washs08.asp.
7. See, e.g., infra notes 188–189; Sun Go & Peter Lindert, "The Uneven Rise of American Public Schools to 1850," 70 *J. Econ. Hist.* 1, 3 (2010).
8. See, e.g., An Act to Admit the State of Texas to Representation in the Congress of the United States, ch. 39, 16 Stat. 80, 81 (1870); An Act to Admit the State of Mississippi to Representation in the Congress of the United States, ch. 19, 16 Stat. 67, 68 (1870); An Act to Admit the State of Virginia to Representation in the Congress of the United States, ch. 10, 16 Stat. 62, 63 (1870).
9. See supra notes 210–212, 319–324.
10. *Id.*
11. *Id.*
12. 13 Stat. L., 507, ch. 90 (1865).
13. Lawrence A. Cremin, *American Education: The National Experience 1783–1876* 517–18 (1980).
14. 14 Stat. 428, Chap. 153 (March 2, 1867).
15. Statutes at Large, 39th Cong., 2d Sess., ch. 158, at 434, <https://memory.loc.gov/cgi-bin/ampage?collid=llsl&file=014/llsl014.db&recNum=465>.
16. *Id.*
17. Black, supra note 2; Wiener & Pristoop, supra note 32, at 5, 6 (stating that Goodwin Liu uses a 60% adjustment for poor children, while the authors use a 40% adjustment).
18. No Child Left Behind Act, Pub. L. No. 107–110, §§ 1124, 1125A (setting the standard for whether low-income schools are fairly funded as whether they receive a 40% funding increase adjustment); Nat'l Ctr. for Educ. Statistics, supra note, at 62 (identifying 40% as the appropriate adjustment for low-income students); U.S. Gen. Acct. Off., supra note, at 30.
19. Liu, supra note 40, 983–84.
20. Liu, supra note 296.
21. Connecticut, Maryland, Illinois, and Pennsylvania, for instance, are among the nation's wealthiest states and expend amongst the highest levels on education, but they distribute those funds very unequally among districts. Baker et al., supra note 28, at 25.
22. Joshua E. Weishart, "Transcending Equality Versus Adequacy," 66 *Stan. L. Rev.* 477 (2014).
23. *South Dakota v. Dole*, 483 U.S. 203 (1987); *NFIB v. Sebelius*, 132 S. Ct. 2566 (2012).
24. Benjamin Michael Superfine, "Using the Courts to Influence the Implementation of No Child Left Behind," 28 *Cardozo L. Rev.* 779, 790 (2006).
25. See generally Berry, supra note 230, at 233.
26. See, e.g., *United States v. Virginia*, 518 U.S. 515 (1996).
27. For an overview of Title IX's developments over the years, see Paul M. Anderson, "Title IX at Forty: An Introduction and Historical Review of Forty Legal Developments That Shaped Gender Equity Law," 22 *Marq. Sports L. Rev.* 325 (2012).
28. Women's Sport Found., *Play Fair: A Title IX Playbook for Victory* (2009).
29. *Id.*
30. *Id.*
31. Utah's progressive funding, moreover, may be happenstance — a result of unique demographics and overall low education funding levels. Bruce Baker and colleagues have published national reports five out of the last seven years. Those reports can be downloaded at http://www.schoolfundingfairness.org/downloads_popup.htm#. Two other states — Minnesota and Delaware — could have hovered close to compliance in individual years but never would have met it.
32. *Id.*
33. See generally *The Nation's Report Card: Evolutions and Perspectives* (2004).
34. See generally Ryan, supra note 1 (pointing out the flaws of relying on state-based tests).
35. See generally Molly S. McUsic, "The Future of *Brown v. Board of Education*: Economic Integration of the Public Schools," 117 *Harv. L. Rev.* 1334, 1350–54 (2004); U.S. Dep't. of Educ., Press Release, "More than 40% of Low-Income Schools Don't Get a Fair Share of State and Local Funds, Department of Education Research Finds" (Nov. 30, 2011).
36. One of most consistent objections to the ESEA and other education legislation is that the federal government is intruding on an area that is reserved to state control. See, e.g., *United States v. Lopez*, 514 U.S. 549 (1995); Michael D. Barolsky, "High Schools Are Not Highways: How Dole Frees States from the Unconstitutional Coercion of No Child Left Behind," 76 *Geo. Wash. L. Rev.* 725 (2008).
38. Ryan, supra note 35, at 52 ("researchers have uniformly demonstrated [that] the benefits of preschool...easily...outweigh the costs").

Start with Equity

Discipline, Inclusion, and Dual-Language Learning in the Southern United States

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The 2020 census indicates that although the overall child population rate in the United States fell in the last 10 years, on average, several states, many of which are in the Southern United States, saw increases. The census also revealed the increasing diversity in the child population, with white children making up fewer than half of the child population under age 11. For children under age 18, the number of white children dropped between 2010 and 2020 (13%). The number of Black children also fell by less than 1%. The total number of Hispanic/Latino (9%), Asian (23%), and Multiracial (78%) children, on the other hand, increased. In addition, data indicate that more than 11.2 million children, or about one-third of all children under the age of 9 are dual-language learners (DLLs), with significant variation across state lines.¹ California and Texas, in particular, have the largest share of DLLs, with Georgia, Arizona, and Florida among the top 10 states with DLLs.²

Despite the great potential of this growing, rich diversity in our nation's schools and early learning programs, gaps in opportunity in education run rampant. Still, too often, the opportunities afforded to our young children in the US are determined by a child's zip code, their race/ethnicity, their parent's income, or the language they speak at home. The COVID-19 pandemic and its effects on the health, economic well-being, and education of young children only exacerbated existing inequalities.³

The United States is at a crossroads again. We can spend the next several years trying to get back to the broken, ineffective status quo in our learning systems, where children were falling — or being pushed — through the cracks at astonishing rates; or we can choose to address the core, structural inequities that have held back generations of children, especially Black, Latino, and Native American children. For the sake of our country, we hope policymakers respond to the multiple crises facing our nation by addressing the latter.

This Brief

This brief is part of a broader effort led by the Children's Equity Project (CEP), in partnership with the Bipartisan Policy Center (BPC) and several other partner national organizations launched in 2020, to advance access, quality, and equity in learning systems. The CEP and BPC published a report that year, "Start with Equity: From the Early Years to the Early Grades, a Child Policy Agenda." Informed by over 70 experts, the authors extensively reviewed the data, research, and policy landscapes of three key issues in the systems in which young children learn, from birth through the early grades. They include:

- Harsh discipline and its disproportionate application in learning settings;
- Lack of inclusion of young children with disabilities in learning settings; and
- Inequitable access to high-quality learning for dual-language and English learners.

In this brief, we revisit the research, update facts and figures with new data, and pay particular attention to trends and themes in the South, Southwest, and California, considering the growth and diversification occurring across the region. We used data extracted across each issue area specific to these regions.

Each of these issue areas — discipline, inclusion, and dual-language learning — share the common theme of exclusion: exclusion from learning settings altogether, exclusion from inclusive learning opportunities, and exclusion from teaching models that we know work. We believe that shifting to inclusion can transform children's learning experiences and change their trajectories in the long term. The policy agenda provided here can help bridge gaps in opportunity that have long prevented entire generations and communities of children from reaching their full potential.

Southwest and California	South
Nevada, Arizona, New Mexico, Texas, and California	Alabama, Arkansas, Florida, Georgia, Kentucky, Louisiana, Mississippi, North Carolina, South Carolina, Tennessee, and Virginia

A Critical Moment

The public health and economic emergencies this country faces as a result of the COVID-19 pandemic are unprecedented, painful, and large in scale. The pandemic has exposed the precarious economic and social conditions of children and families across the United States, but especially those from historically marginalized communities.⁴

Discriminative housing, financial, labor, education, and criminal justice policies have stacked the deck against people of color.⁵ Today, people of color are less likely to have access to health insurance and are more likely to face bias within the healthcare system.⁶ They are more likely to be exposed to air pollution and lead, live in food deserts and near toxic sites and landfills, and lack access to clean drinking water.⁷ Each of these factors, and others, affect underlying health conditions. The broader long-term effects of COVID on Americans' pocketbooks, education, and other domains of life will be unknown for some time. However, it is a fact that a long history of discriminatory policies has resulted in people of color having less wealth — by some estimates, ten times less — and dramatically less upward economic mobility than their white counterparts.⁸ It is a fact that their children are more likely to attend high-poverty, underfunded schools. It is also a fact that nearly one in three Black and Native American children and one in four Latino children lived in poverty before the COVID-19 pandemic ravaged communities economically. Now, where the data are disaggregated, we know that children of color are also more likely to suffer directly from losing a loved one from COVID.

Our systems have created barriers that stack the deck against many children — and they have to climb over those barriers before they are out of diapers. We have a system that is unequal, unfair, and unsustainable.

If all children are given access to the academic and social-emotional supports they need — instead of being kicked out of school, floundering in ineffective and ideologically driven teaching models, and separated into sub-par learning settings — young children who have been locked out of opportunity for generations could get closer to reaching their full potential. If we seize this moment as an opportunity for positive change, for a long overdue pivot toward equity, maybe we can climb out of this turbulent time in American history stronger and ensure that all of our children, not just some of them, have the opportunity to thrive.

Of course, for the United States to live up to its ideals, an array of social issues must be addressed — from housing and healthcare to immigration and mass incarceration. **Tackling early learning and education alone is not enough, but it is a necessary step to building a more equitable society.**

What We Learned

We identified common themes and learnings across these three key issue areas, they include:

- **Racial disparities** exist across each issue area, across ages, and across states. Children with intersecting identities who have to interact with multiple systems are the most disadvantaged.
- Inequities in learning settings are fueled by a complex array of issues that include **individual and systemic bias, policies, and access to resources**.
- Teacher preparation and professional development is **poorly resourced, and it inadequately and insufficiently addresses equity** in learning.
- **Segregated learning is common**, particularly for English learners and young children with disabilities.
- Federal and state programs for children from historically marginalized communities are **severely underfunded**.
- There is **great variation** in state policies on each of these issues.
- Federal and state monitoring and accountability is either **insufficient or altogether absent**.
- Data gaps across issue areas — but especially on dual-language learners — **obscure a clear understanding** of how systems work and how well they support children.

Policy Steps We Should Take That Can Have an Impact on All of These Areas Collectively:

- Fully funding existing laws designed to support children from marginalized communities, such as IDEA, the Head Start Act, and Titles I and III of the Every Student Succeeds Act.
- Requiring that states report their plans to make child care, early learning, and K–12 education systems fair and quality for all children, especially those who have been historically marginalized, in applications for federal funding and that the federal government ties funding to progress on those plans.
- Ensuring the federal government and states consider uneven opportunity and disparities in outcomes as part of monitoring and accountability in child care, early learning, and K–12 education systems and specifically monitor for disparities in opportunity and outcomes as a result of the COVID-19 pandemic.
- Supporting and funding expansion of diverse educators and better preparation of existing educators that explicitly include a focus addressing opportunity gaps and disparities in outcomes in the classroom.
- Increasing funding for longitudinal, disaggregated data collection of young children across learning settings.
- Ensuring all child care, early learning, and education laws moving forward prioritize racial, ethnic, linguistic, socioeconomic, and ability-based integration.

Major Findings Across Issue Areas

Harsh Discipline and Its Disproportionate Application in Learning Settings:

Positive behavior guidance can help support children's social-emotional development and a healthy classroom and school climate.⁹ However, too often in place of positive behavior guidance, schools and early learning programs use harsh forms of discipline, disproportionately on Black children and some other children of color, which causes harm to children's well-being.¹⁰ **There is no evidence that harsh discipline improves children's behavior in the short term or over time, but there is an abundance of research showing it is associated with poor outcomes.**¹¹ For the purposes of this report, we define harsh discipline as:

- exclusionary discipline via expulsion or suspension;
- corporal punishment;
- seclusion; and
- restraint used inappropriately.

Harsh discipline is common, even in the early years. The data show that harsh discipline practices are used with the youngest children in schools and early learning settings and even occur with infants and toddlers.¹² In a US Department of Health and Human Services survey, parents reported that **approximately 50,000 children under five were suspended, and 17,000 were expelled, in a single year.**

In an analysis of pre-K through elementary school systems, the Southern and Southwestern states and California (i.e., Arizona, Alabama, Arkansas, California, Florida, Georgia, Kentucky, Louisiana, Mississippi, Nevada, New Mexico, North Carolina, South Carolina, Tennessee, Texas, and Virginia) reported roughly 500,000 cases of suspensions, more than double the amount of all other states.

When it comes to corporal punishment, defined as paddling, spanking, or other forms of physical punishment imposed on a child, there are no federal laws or regulations governing the practice other than those authorizing data collection. The practice remains legal in 19 states — 13 of which are in the South or Southwest. National data from the US Department of Education show that roughly 70,000 children across age groups were subject to corporal punishment during a given year. **More than 800 of these were preschool students.**

When it comes to physically restraining children, the latest data show 74,000 K–12 children were restrained over the course of a year, and 27,500 children were subject to seclusion, the practice of locking children in a room alone without the ability to get out. These practices were never supposed to be commonplace; they were developed to be used exclusively for emergencies and to mitigate physical harm.

In the Southern United States and California, nearly 290,000 children in pre-K and elementary schools were suspended or expelled, 30,500 were corporally punished, and 18,000 were restrained and secluded.

It is disproportionate. This is all happening inequitably. National data from public schools show that Black children, Black children with disabilities, and children with disabilities broadly are disproportionately harshly disciplined.

In K–12 settings, Black children make up 15% of the total enrollment but 38% of those suspended at least once, 37% of those corporally punished, 29% of those restrained, and 23% of those secluded. The data also reveal disparities between children with disabilities and those without. These disparities are present across all forms of discipline. Of all K–12 children, children with disabilities represent 13% of the total enrollment but 25% of those suspended at least once, 17% of children corporally punished, **78% of children restrained, and 77% secluded.**

Examination of the data by race/ethnicity and disability shows that Black children with disabilities are more harshly disciplined than all other races/ethnicities. For example, Black children with disabilities represent 18% of all K–12 children with disabilities, but 40% of those suspended one or more times, 52% of those physically restrained, and 60% of those secluded. They are also about twice as likely to be corporally punished as their white peers.

These same patterns are true in pre-K through elementary schools. For example, in pre-K settings, Black children represent 18% of total pre-K enrollment yet 43% of children suspended one or more times.

There are roughly 5.73 million children enrolled in the pre-K and elementary schools in the South. Black children represent 28.10% of the enrollment in the South and white children represent 46.48% of the enrollment. The percent of children with disabilities in pre-K and elementary schools in these states (14.23%) is slightly higher than the national average (13.89%).

Similar to national trends, there are stark disproportionalities across all forms of discipline for Black children. While Black children represent 28.10% of the total pre-K and elementary school enrollment in the South, they represent 60.02% of children suspended and expelled, 47.70% corporally punished, and 38.33% restrained and secluded.

There are about 6.36 million children enrolled in pre-K and elementary schools in the Southwest and California. Latino children represent 54.35% of the total enrollment in these states, followed by white and Black children, at 24.82% and 8.75%, respectively. While Black children only represent 8.75% of the total enrollment in these states, they comprise 25.73% of one or more out-of-school suspensions, 18.37% of corporal punishment, and 22.79% of restraints and seclusion in these grades. As the largest student population in the region, Latinos are not disproportionately over-represented in any of the discipline areas.

Table 1: Number of and Disparity in Suspensions per 1,000 Students across Southern and Southwestern States and California.

States	All Students	Black Students	Disparity
Arizona	25.49	75.33	49.84
South Carolina	50.75	95.19	44.44
Tennessee	26.13	70.37	44.24
North Carolina	37.85	81.98	44.13
Virginia	27.06	68.28	41.22
Kentucky	19.71	60.82	41.11
California	14.10	53.82	39.72
Alabama	35.53	72.88	37.35
Arkansas	34.35	69.85	35.50
Nevada	21.04	51.61	30.57
Mississippi	59.34	89.79	30.45
Georgia	31.30	60.94	29.64
New Mexico	20.14	47.74	27.61
Florida	23.73	49.45	25.72
Louisiana	38.79	62.35	23.55
Texas	11.32	33.61	22.29

Table 2: Number of and Disparity in Corporal Punishment per 1,000 Students across Southern and Southwestern States and California.

States	All Students	Black Students	Disparity
Mississippi	42.15	55.32	13.17
Arkansas	22.65	31.38	8.74
Louisiana	2.23	3.42	1.19
Georgia	2.66	3.77	1.11
Tennessee	3.26	4.23	0.97
Texas	1.99	2.85	0.86
Alabama	11.65	11.97	0.32
Florida	0.53	0.64	0.11
South Carolina	0.04	0.06	0.02
Virginia	0.00	0.00	0.00
California	0.00	0.00	0.00
New Mexico	0.00	0.00	0.00
Arizona	0.00	0.00	0.00
Nevada	0.00	0.00	0.00
North Carolina	0.01	0.00	-0.01
Kentucky	0.30	0.03	-0.27

Table 3: Number of and Disparity in Restraint and Seclusion per 1,000 Students across Southern and Southwestern States and California.

States	All Students	Black Students	Disparity
Kentucky	5.91	17.82	11.91
Nevada	3.90	10.74	6.85
Arizona	2.80	9.30	6.51
Texas	1.47	2.94	1.46
California	0.46	1.56	1.09
Florida	1.69	2.63	0.94
New Mexico	0.83	1.71	0.88
Virginia	1.39	2.26	0.87
Alabama	2.27	3.14	0.87
Tennessee	1.99	2.59	0.60
South Carolina	1.05	1.53	0.48
Georgia	1.95	2.40	0.45
North Carolina	0.47	0.87	0.40
Arkansas	1.03	1.27	0.23
Mississippi	0.90	1.06	0.16
Louisiana	0.26	0.29	0.03

State policies and practices vary. We calculated suspension rates for Black children as compared to their peers, and we found racial disparities in every single state. Of the states in the Southern United States and California, South Carolina (95.19) and Mississippi (89.79) had the biggest difference in rates at which Black children (pre-K through elementary school) were suspended compared to all other children.

Corporal punishment is legal in private school settings in every state in the nation except two (New Jersey and Iowa) and is legal in public school settings in 19 states. The majority of public school corporal punishment cases occur in **Mississippi, Arkansas, Alabama, and Texas.**

Policies and practices around seclusion and restraint also vary by state. Only two states, Georgia and Hawaii, ban seclusion outright. A handful ban it for children with disabilities. There are no limits on restraining children in nearly half the states.

What is fueling these practices and disparities?

There is no evidence that Black children show greater or more severe misbehavior. Instead, research suggests Black children are punished more severely than their peers for the same or similar behaviors and that they are subject to increased scrutiny as early as preschool. Well-established research suggests that Black children are often the subjects of implicit bias, with adults perceiving Black children as being older than they are, less innocent than their peers, more culpable and aggressive, and more deserving of harsher punishment than white children.¹³

Meaningful change is not coming fast enough. Data in K–12 settings indicate that racial disparities in corporal punishment and exclusionary discipline today are largely consistent, or larger, than when data were first published **more than 40 years ago.** Encouragingly, between the two most recent data collection periods, exclusionary discipline children in public pre-K settings fell sharply. Unfortunately, those drops in the rate were not accompanied by a narrowing of disparities. Indeed, data indicate the same stark disparities, with Black children being over-represented across every domain of discipline.

Lack of teacher training and ongoing supports are key. One national representative survey found that only 20% of early childhood providers received training in social and emotional development in the previous year.¹⁴ Research finds that when teachers have access to an early childhood mental health specialist, suspensions and expulsions can drop by half.¹⁵

Disparities in access to social-emotional support is also a factor. Children of color have less access to early childhood mental health specialists in early learning settings; in K–12 settings, they disproportionately attend schools with no or insufficient counselors and mental health professionals.¹⁶

Implicit and explicit bias is also an underlying driver of the uneven application of harsh discipline.¹⁷ Black children face disparities across all forms of harsh discipline and across all age groups.¹⁸

Finally, the poor working conditions and low compensation of the early care and education and K–12 education workforce contribute to increased stress and mental health challenges, including depression, which, when paired with a lack of support and training, can contribute to these practices.¹⁹

Solutions begin with policy change. Congress should:

- pass legislation to end corporal punishment and seclusion across all learning settings that receive federal funding;
- pass legislation to limit exclusionary discipline in young learners;
- eliminate the 10-day suspension allowance for children with disabilities in IDEA;
- require data collection on exclusionary discipline, corporal punishment, and restraint and seclusion across all early childhood programs that receive public funding, including child care settings;
- increase funding for social-emotional-focused interventions, coaching, and personnel; and
- increase funding to improve workforce working conditions, including increasing compensation, reducing ratios and group sizes, ensuring paid leave, and hiring substitutes.

Lack of Inclusion of Young Children with Disabilities:

Since the passage of the Individuals with Disabilities Education Act (IDEA) nearly 50 years ago, federal law has been clear: All eligible school-aged children with disabilities are guaranteed a free and appropriate public education in the least restrictive environment.

The legal foundation for inclusion is supported by a vast body of research that shows that inclusion has many benefits for children with and without disabilities.²⁰ Children with disabilities in high-quality, inclusive early learning programs make larger gains in their cognitive, communication, and social-emotional development than their peers with disabilities in segregated settings.²¹

Despite this knowledge, progress has been slow. **The number of children receiving education services in inclusive settings has not substantially increased in decades.**²² This is especially so in the preschool years: data show the number of children with disabilities ages three to five who received special education services in inclusive settings has inched up by only about 5% since the 1980s.²³ For years, up until very recently, more than half of preschoolers with disabilities were still receiving their services in segregated settings. Interestingly, in the 2019–2020 school year, this number increased more than it had in several years, reaching 58%. This may be due to a greater number of students with disabilities learning virtually, alongside their peers without disabilities. According to these data, Native American and white children receive their services in inclusive settings at the highest rates (69% and 62%, respectively), while Black (59%), Latino (58%), Multiracial (59%) children are slightly less likely to receive special education services in inclusive environments. Hawaiian Native/Pacific Islander (51%) and Asian (50%) were the least likely to receive their services in inclusive settings.

Public pre-K is an underused lever to increase inclusion. States with robust public pre-K systems should have a higher percentage of children with disabilities receiving services in inclusive early learning settings, given the greater number of early learning slots. However, a 2020 analysis we conducted found that access to pre-K in states was not related to the proportion of children with disabilities receiving services in inclusive settings.

- States with the highest rates of providing services to **preschool children** with disabilities in general education early childhood programs are Colorado, Nebraska, Vermont, Ohio, and Connecticut.
- States with the lowest rates of providing preschool children with services in inclusive settings are Louisiana, Idaho, Hawaii, California, and Arkansas.
- States with the highest rates of enrolling school-aged children with disabilities receiving special education in regular classes for 80% or more of their day are Alabama, Nebraska, Florida, Colorado, and Kentucky.
- States with the lowest rates of school-aged children with disabilities receiving their special education services in regular classes for 80% or more of their day are Hawaii, New Jersey, Montana, Missouri, Arkansas, and Illinois.

There are disparities when it comes to who gets access to inclusive learning. Disparities exist in terms of who has access to inclusive education, with children with certain disability diagnoses being less likely to receive most of their special education services in inclusive settings. In particular, only 14.3% of children and youth with multiple disabilities, 16.16% of children and youth with intellectual disabilities, 26.5% of children with Deaf-Blindness, and 39.8% of children with Autism receive their special education services for 80% or more of their day.

Black children are overrepresented in special education, but not in early intervention. In examining the intersections between race and disability category, Black children are at least twice as likely to be identified with an intellectual disability or emotional disturbance than all other racial/ethnic groups combined; children with these disabilities are less likely to spend time in general education classrooms than their peers with other disabilities.²⁴ In some places, the result is segregated special education placements that tend to mirror racial segregation patterns of the past.²⁵

One major barrier to inclusion is ableism,²⁶ which influences teacher and administrator attitudes and beliefs around children with disabilities and their inclusion in learning settings, educator training on practices that support inclusion, and the need for meaningful state reforms and funding increases.

Table 4: Part B 619 Preschoolers (3-5 y.o.) setting of special education services in the Southwestern and Southern states by race and ethnicity

(Data Source: 2019 Data from 43rd Annual Report to Congress)

	American Indian		Asian		Black		Hispanic		Hawaiian/Pacific Islander		Multiracial		White	
	Inclusive	Segregated	Inclusive	Segregated	Inclusive	Segregated	Inclusive	Segregated	Inclusive	Segregated	Inclusive	Segregated	Inclusive	Segregated
Southwest	55%	44%	37%	63%	44%	60%	49%	55%	53%	55%	43%	57%	45%	56%
California	46%	54%	32%	68%	33%	70%	39%	61%	39%	61%	40%	60%	42%	59%
Nevada	43%	57%	45%	54%	47%	53%	46%	54%	46%	54%	47%	53%	48%	52%
Arizona	53%	47%	16%	84%	26%	74%	34%	66%	34%	66%	30%	70%	30%	70%
New Mexico	78%	22%	NR	NR	57%	NR	68%	NR	86%	NR	41%	NR	49%	NR
Texas	57%	40%	56%	44%	58%	41%	60%	40%	60%	40%	56%	44%	58%	42%
South	67%	33%	44%	54%	62%	40%	55%	55%	56%	47%	59%	40%	62%	37%
Arkansas	71%	30%	57%	43%	70%	30%	67%	33%	67%	33%	75%	25%	72%	28%
Louisiana	57%	43%	NR	NR	91%	0.90%	85%	NR	84%	NR	NR	NR	85%	15%
Alabama	NR	NR	64%	36%	82%	19%	67%	33%	67%	33%	89%	11%	76%	24%
Mississippi	50%	50%	38%	62%	65%	35%	46%	54%	46%	54%	50%	50%	58%	42%
Tennessee	62%	39%	37%	64%	48%	52%	41%	59%	41%	59%	56%	44%	52%	48%
Kentucky	100%	0%	96%	0.04%	96%	38%	96%	0.04%	96%	0.04%	50%	50%	93%	0.08%
Georgia	67%	33%	28%	72%	48%	52%	40%	60%	40%	60%	95%	0.04%	51%	49%
Florida	67%	33%	0.26%	74%	31%	69%	38%	62%	38%	62%	33%	67%	40%	60%
South Carolina	92%	0.08%	45%	55%	54%	46%	47%	53%	47%	53%	48%	52%	52%	48%
North Carolina	70%	30%	43%	57%	53%	47%	43%	55%	45%	55%	54%	46%	58%	42%
Virginia	33%	67%	28%	72%	44%	56%	40%	60%	40%	60%	44%	56%	49%	51%

Inclusion of Children with Disabilities in Southern and Southwestern States

- As seen in Table 4 on page 20, on average, **52% of preschoolers ages 3–5 years old across the Southern US and California** receive special education services in inclusive settings. Regionally, preschoolers are more included in the South, compared to the Southwest and California, with 47% of preschoolers with disabilities receiving instruction in inclusive settings in the Southwestern region of the US, compared to 57% of preschoolers in the South.
- Arizona (30%), California (34%), Florida (35%), and Virginia (36%) have the lowest average inclusion rates.
- Across both the Southern and Southwestern states, Asian preschoolers are more likely to receive services in segregated settings. Only 41% of Asian preschoolers receive special education services in inclusive classrooms, compared to 51% of preschoolers from other racial and ethnic backgrounds.
- As seen on Table 5, similar patterns emerge in K-12 settings, with students in the South more likely to spend more time in general education settings. On average, 62% of school-aged children and youth in the Southwest and California receive their special education services inside regular classrooms for 80% or more of the day, whereas 71% of these children and youth receive inclusive instruction in the South.
- Across the Southwestern and Southern states, Mississippi (76.4%), Florida (75.7%), Texas (71%), Tennessee (71%) have the highest proportion of school-aged children and youth receiving inclusive instruction in regular classrooms for 80% or more of their day, while California (58.4%) and New Mexico (51.4%) have the lowest rates.

Table 5: Part B 611 Percentage of School-Aged Children and Youth (5-21 years old) in the Southwestern and Southern states who receive special education services inside regular classrooms for 80% or more of the day

(Data Source: 2019 Data from 43rd Annual Report to Congress)

States	Inside regular classroom 80% or more of the day
Southwest	62%
California	58.4%
Nevada	61.2%
Arizona	68.0%
New Mexico	51.4%
Texas	71.0%
South	71%
Arkansas	56.9%
Louisiana	63.9%
Alabama	83.6%
Mississippi	76.4%
Tennessee	71.0%
Kentucky	73.9%
Georgia	62.7%
Florida	75.7%
South Carolina	62.5%
North Carolina	67.8%
Virginia	67.8%

Solutions begin with policy change. Congress should:

- fully fund IDEA;
- increase funding for infants and toddlers with disabilities;
- increase funding for training for personnel, monitoring, and accountability efforts;
- strengthen IDEA provisions on inclusion, include reporting and accountability for increases in inclusion, and ensure inclusion is used as a factor in funding redetermination; and
- request Government Accountability Office (GAO) reports on the costs of adequately funding inclusive services and on the effects of failing to fully fund IDEA on child outcomes.

Inequitable Access to High-Quality Learning Opportunities for Dual-Language and English Learners

Dual-language learners (DLLs) are young children who are learning a second language while continuing to develop their first language. Once they enter the K–12 system, DLLs who are not proficient in English are formally classified as “English learners” (ELs) and are eligible for services to aid their English language development.

DLL and EL children are a large, diverse, and growing population. It is estimated that about 32% of children, approximately 11 million, in the country under eight years old are DLLs.

DLLs in the South and Southwestern Regions of the US. As seen in Table 6 on page 23, DLLs between the ages of zero and eight represent 48% of the children in the Southwestern states of the US and California and 18% of young children in the Southern states. In the Southwestern region, California and Texas have the most DLLs, comprising 60% and 50% of the population, respectively. In the South, Florida (42%), Virginia (27%), and North Carolina (22%) have the highest proportions of young DLLs. **On average, 94% of these young children were born in the United States.** While Spanish is the most commonly spoken language across both regions of the US, there is great variability in the other languages DLLs speak at home, and this differs based on the state. Additionally, on average, 29% of young DLLs in the South and Southwestern regions of the US live in communities that are under-resourced, making it important to provide them with the support and resources they deserve to thrive as emergent bilingual speakers.

As a subgroup, DLL and EL children have a host of linguistic, cultural, and social strengths.²⁷

Their bilingualism is associated with cognitive advantages, including strong executive functioning skills, attention perspective-taking, and self-regulation.²⁸

The research is clear: The gold standard in instruction is high-quality dual-language immersion.²⁹

Such programs provide instruction in two languages and typically have balanced enrollment between native speakers of each of the languages used.

Dual-language immersion models are associated with improved developmental, linguistic, and academic outcomes for all students. Research shows that having access to learning experiences in a child’s home language alongside English strengthens the language foundation upon which literacy grows, provides meaningful access to the curriculum, and can foster teacher–child relationships.³⁰ However, despite the advantages of bilingualism and the superiority of bilingual learning models, our learning systems are overwhelmingly depriving DLLs and ELs of such opportunities.

Table 6: Overview of Dual Language Learners 0-8 years old in the Southwestern and Southern states of the U.S.
(NR: Not Reported)

Racial and Ethnic Backgrounds of DLL Children													
States	Total DLL Child Population (0-8)	% of All Children	Latino	Non-Latino Black	Non-Latino AAPI	Non-Latino White	Non-Latino Other	U.S. Born	Top 5 languages				
Southwest		48%	73%	4%	12%	8%	4%	95%					
California	2,547,000	60%	69%	2%	19%	9%	1%	95%	Spanish (65%)	Chinese (5%)	Tagalog (3%)	Vietnamese (2%)	Korean (1%)
Nevada	140,000	44%	73%	5%	13%	8%	1%	96%	Spanish (70%)	Tagalog (6%)	Amharic/ Ethiopian (3%)	Chinese (3%)	Vietnamese (1%)
Arizona	312,000	41%	66%	5%	15%	12%	n/a	93%	Spanish (68%)	NR	NR	NR	NR
New Mexico	99,000	44%	75%	NR	3%	6%	14%	97%	Spanish (67%)	Navajo (9%)	NR	NR	NR
Texas	1,718,000	50%	80%	4%	9%	7%	0%	95%	Spanish (78%)	Vietnamese (1%)	Chinese (1%)	Arabic (1%)	Hindi (1%)
South		18%	54%	10%	14%	20%	—	93%					
Arkansas	43,000	13%	66%	5%	15%	12%	NR	93%	Spanish (68%)	NR	NR	NR	NR
Louisiana	56,000	11%	50%	10%	15%	25%	NR	93%	Spanish (55%)	Vietnamese (6%)	French (6%)	Arabic (5%)	Chinese (3%)
Alabama	50,000	10%	60%	10%	13%	16%	NR	94%	Spanish (64%)	Arabic (4%)	Vietnamese (3%)	Korean (2%)	French (2%)
Mississippi	22,000	7%	50%	11%	13%	21%	4%	95%	Spanish (57%)	Arabic (5%)			
Tennessee	101,000	15%	56%	10%	12%	21%	NR	92%	Spanish (58%)	Arabic (5%)	Chinese (2%)	French (2%)	German (2%)
Kentucky	52,000	11%	37%	14%	14%	34%	NR	92%	Spanish (40%)	German (10%)	Arabic (4%)	Somali (3%)	Nepali (2%)
Georgia	268,000	23%	55%	13%	16%	14%	1%	93%	Spanish (58%)	French (2%)	Chinese (2%)	Hindi (2%)	Vietnamese (2%)
Florida	809,000	42%	64%	13%	6%	16%	1%	93%	Spanish (67%)	Haitian Creole (9%)	Portuguese (2%)	Arabic (1%)	French (1%)
South Carolina	66,000	13%	55%	6%	13%	24%	NR	92%	Spanish (58%)	Chinese (3%)	Russian (3%)	German (2%)	Arabic (2%)
North Carolina	237,000	22%	63%	8%	15%	13%	1%	93%	Spanish (65%)	Arabic (2%)	French (2%)	Telugu (2%)	Chinese (2%)
Virginia	234,000	27%	42%	12%	24%	21%	1%	92%	Spanish (45%)	Arabic (5%)	Chinese (3%)	Amharic (3%)	Telugu (2%)

There is a lack of bilingual education nationwide. In some places where bilingual learning does exist, DLLs and ELs are underrepresented; in other places, they are locked out as a matter of policy.

English immersion, or “English-only” programs, are commonplace for DLLs and ELs, but they are not effective. In K–12 settings, these models sometimes result in the segregation of students learning English. Some research finds that the extent of segregation between these students and their peers is the largest contributor of educational outcome gaps between the groups.³¹ Research shows DLLs who are first exposed to English in kindergarten and remain in English-dominant instructional environments tend to fall behind their early-proficient and monolingual English-speaking peers on academic skills (as measured in English).

This has contributed to a gap between DLLs' and ELs' potential and their outcomes. Beyond a lack of access to appropriate learning approaches, this gap is tied to a societal bias in the United States in favor of monolingualism. Tests and assessments are primarily conducted in English, and bilingualism is only valued for some and seen as a deficit for DLLs and ELs. Combined, these factors disadvantage children and create misperceptions about DLLs' and ELs' potential.

For DLLs, bilingual learning is not an optional enrichment as it is for children who speak English as a first language. **It can make or break their access to a quality education altogether. It is the difference between enrichment and equity.**

Assessment problems cannot be overlooked. In addition to improving access to high-quality bilingual learning models, we need better assessments for DLLs and ELs so we can effectively measure both student progress and program effectiveness. Too often, assessments are conducted exclusively in English, which end up assessing a child's English skills rather than subject matter content. And although the field lacks assessment tools in many languages, there are tools in Spanish — by far the most commonly spoken language by DLLs and ELs in this country, that are not being used enough.

Other obstacles to success are also significant. The national shortage of credentialed bilingual teachers limits access to strong dual-language programs. In addition, research finds that teacher bias and differential expectations for DLLs and ELs also impact the success of young learners. Nationally representative data show that teachers have lower academic expectations for children classified as ELs; though, this is not the case in bilingual schools. Similarly, in countries that place value on speaking multiple languages, the academic differences between monolingual and bilingual children are small or nonexistent.

The Federal and State Policy Landscape:

- Head Start has the most comprehensive standards for DLLs across early learning systems, though they are not perfect.
- The federal K–12 Every Student Succeeds Act (ESSA) of 2015 shifted more responsibility for decision making and accountability for English learners to the states.
- Title III funding under that federal law is designed to support ELs, but it has been stagnant and has not kept up with inflation or the increase in the number of ELs in the country.
- A number of states and districts, including Utah, Delaware, North Carolina, New York City, and Washington, D.C., are trying to expand access to bilingual learning programs.
- A total of 35 state-funded pre-K programs have policies to support DLLs, although no state has a comprehensive set of policies.
- Only one state, Illinois, explicitly requires bilingual instruction if there are 20 or more DLLs with the same home language enrolled in the same program.
- Only 15 states discuss the learning and developmental needs of DLLs in their early learning and development standards. Only New Jersey has a dual-language approach; every other state has an English-focused approach.
- Notably, at the time of publication of this report, Arizona was the only remaining state with an English-only mandate for ELs in K–12 settings, although key provisions in the law were recently rolled back. California and Massachusetts repealed their English-only laws in 2016 and 2017, respectively.

Solutions begin with policy change. Congress should:

- at least triple the funding for students learning English through Title III of ESSA;
- request a GAO study on federal funding for DLLs/ELs;
- require alignment between any future federal early learning funding with Head Start program performance standards, particularly the DLL related standards;
- fund the piloting and evaluation of strengths-based bilingual learning programs; and
- provide the Department of Education with funding to launch competitive grant programs to support bilingual teacher training programs.

Looking Ahead

The COVID-19 pandemic has exposed and exacerbated longstanding inequities in our learning systems, starting at the youngest ages. The time for change is now — especially now. Policymakers' responses to both the pandemic and to the uprising against racial injustice will determine whether children continue to be locked out of opportunity for another generation — or longer — or are given the fair chance they deserve to reach their full potential. Our policy agenda helps move us in the direction of the latter.

These and other reforms that address inequities in learning are critical to our economy, our capacity to be competitive on a global scale, and our ability to live up to the core principles of equality on which this country was founded. Even more fundamentally, they are necessary because all children deserve the chance to reach their full potential, regardless of what they look like, where they are from, or what disability they may have. We can and must do better.

Read our full report at <https://childandfamilysuccess.asu.edu/cep/start-with-equity> for the complete set of recommendations across all levels of government.

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To Lift Up Black Families, Provide Them a Guaranteed Income

Dr. Aisha Nyandoro, Springboard to Opportunities

This essay is adapted from Aisha Nyandoro's contribution to the report of the Congressional Caucus on Black Women and Girls, *An Economy for All: Building a "Black Women Best" Legislative Agenda*

When it comes to focusing on children in the American South and the policies that best address the persistent racial and economic disparities they face, I believe unrestricted cash in the form of a guaranteed income is the most direct and effective answer. A guaranteed income is an unconditional monthly cash payment, generally in the range of \$500–\$1,000, given directly to individuals — with no restrictions on how the money can be spent and no work requirements imposed for qualification.

Payments are meant to supplement, rather than replace, the existing social safety net; when targeted by income, they can be a critical tool for improving racial and gender equity as women and Black and Brown Americans are more likely to live in poverty.

Guaranteed income is rooted in a history of racial justice — Dr. Martin Luther King Jr. called for guaranteed income as the simplest and most effective solution to poverty. The Black Panthers included guaranteed income in their platform for economic justice, and Black women led the charge on the proposal through the work of Johnnie Tillmon and the National Welfare Rights Organization.

I have seen the transformative effects of a guaranteed income firsthand as the head of the Magnolia Mother's Trust (MMT), the longest-running guaranteed income pilot in the country and the only one in the world to focus on Black mothers and their children. In 2018, my organization, Springboard to Opportunities, began disbursing \$1,000 monthly for a year to mothers living in extreme poverty. We are now entering our fourth cohort, which will include 100 women. One can look to MMT for reason to be optimistic about the impact of a federal guaranteed income on women and kids in the South — our results show the undeniable impact of investing in women: 27% of moms were more likely to go to a doctor if they were sick; 20% were more likely to have children performing above grade level; more than double the number of households were preparing the majority of their food at home; recipients were able to pay off thousands of dollars in predatory debt.

While there are more than 90 guaranteed income pilots across the country, most — like mine — are privately funded. To scale the idea up to a national policy, guaranteed income payments would be funded and distributed by the federal government. Policy related to guaranteed income is in its infancy, due to a long-standing hesitation among many members of Congress to align themselves with an idea that has traditionally been thought of as “radical” — to trust poor people to make their own financial choices without restrictions and heavy bureaucracy.

The COVID-19 pandemic has brought the idea of unrestricted cash into a bipartisan conversation, with a shared understanding that when constituents are dealing with an unparalleled health and economic crisis, getting them help quickly and efficiently must be the government's priority.

This shift has proven what advocates of guaranteed income have been saying for years — cash works. For instance, an analysis of stimulus check impact found that thanks to the most recent checks between December 2020 and April 2021, food insufficiency fell by more than 40%, financial instability fell by 45%, and adverse mental health symptoms fell by 20%.¹

As attitudes have evolved in favor of guaranteed income, with recent polling² indicating that a bipartisan majority of voters support it, potential policy solutions have emerged. This includes Rep. Bonnie Watson Coleman's Guaranteed Income Pilot Program Act,³ which would establish a three-year nationwide pilot program that gives a monthly support payment to individual taxpayers, implemented by the U.S. Department of Health and Human Services (HHS).

And it's not just proposed legislation; we have already seen policies implemented that provide the benefits of unrestricted cash. The expanded Child Tax Credit (CTC) is the closest we've seen to a federal guaranteed income program, when it gave most parents in America (covering 88% of children) up to \$300 a month starting in July 2021. The Build Back Better bill would have extended it through 2022. While this legislation has not advanced, we've seen the dire effects losing the credit has had on families — just a single missed payment in January 2022 sent child poverty soaring more than 40%.⁴

The impact of the expanded CTC was tremendous — data showed significant decreases⁵ in food insecurity and child poverty, with 3 million kids lifted from poverty after just one payment.⁶ In September 2021, more than 400 economists signed a letter⁷ to the Biden Administration endorsing a permanent extension of the policy, including full refundability to ensure that the lowest-income families can receive it.

Parents spent their CTC checks on covering basic needs: the most common uses of the first two CTC payments were purchasing food for their family (51%), followed by paying essential bills (36%) and buying clothing and other essentials for their children (30%).⁸

Some leaders have indicated a desire to attach work requirements to the policy. In fact, recent studies⁹ have shown that direct cash programs like the CTC don't discourage employment and often result in people working more because they are able to afford full-time child care. According to an analysis by the Center on Budget and Policy Priorities, work requirements would exclude children in the most vulnerable families and expose them to ongoing severe hardship.¹⁰

The expanded CTC is especially critical as low-income families, who are more likely to be Black and Brown, struggle against rising costs. Some pundits have blamed programs like the CTC for higher prices, but new data show that the leading cause¹¹ of inflation is corporations raising prices to pad their profits, not to offset their own production costs. In fact, even moderate economists have stated that the expanded CTC does not contribute to inflation¹² and is a needed tool to help families absorb the shock of higher prices.

When it comes to advancing equity, one of the most compelling proposals in this space is *A Guaranteed Income for the 21st Century*,¹³ authored by Naomi Zewde, Kyle Strickland, Kelly Capatosto, Ari Glogower, and Darrick Hamilton. This policy would eliminate poverty overnight. The proposal offers a reconfiguration of the tax code to eradicate poverty immediately through a federal guaranteed income: "We propose that the federal government use its most powerful fiscal tool, the U.S. tax code, to guarantee income and promote economic security for all families, especially communities of color who have been marginalized by our current economic system. A substantial overhaul and extension of the Earned Income Tax Credit (EITC), including the elimination of wage-earning requirements to qualify, would serve as a vehicle to eliminate poverty, build economic equity and lift more families to the middle class. Our proposal to implement a progressive tax code to fund a guaranteed income for families who earn low incomes would essentially eliminate poverty, as designated by federal poverty-level determinations, in America."

As outlined in the report:

- The proposal eliminates wage-earning requirements and dramatically extends the negative income tax feature of the EITC to guarantee income, eliminate poverty, and lift more families to the middle class.
- This program would provide a substantial level of economic support to Americans who need it most. The program eliminates poverty: every individual is guaranteed an income above the federally defined poverty line. Every individual adult would be qualified to receive annual monetary support of up to \$12,500 per year, regardless of household composition or filing status. Every household would also receive additional annual support of up to \$4,500 per child.
- The support would be provided in monthly installments. A defining innovation is that the program removes the wage-earning requirement to qualify. The proposal is designed to supplement, not replace, the existing social safety net. It would lift all households — both wage-earning and non-wage-earning — out of poverty and lift millions more to the middle class.
- Among the nearly 14 million U.S. households in poverty (pre-pandemic), all would be lifted above the poverty line after implementing our guaranteed income program, virtually eliminating poverty in this country.
- Among Black households at baseline, a far greater share is currently below the poverty line: approximately 18%, or 3.6 million households. Each of these households would be lifted out of poverty, with most (2.96 million) between 100% and 200% of poverty.

In recent years, several programs with a focus on uplifting Black women through a guaranteed income have emerged. The longest-running of these is MMT, my program focused on Black mothers living in subsidized housing in Jackson, Mississippi. The average annual income of these women pre-pilot was less than \$12,000, so the program effectively doubled their income. Still, many remained below the poverty line, showing how far we need to come to truly support the economic health of Black women living in poverty.

I crafted MMT along with a group of women in the Springboard community. By designing the program collaboratively with those who would be served by it, MMT offers a framework for building policies based on those who are affected — a privilege that had never been afforded to poor Black women and their children until now.

Centering recipients in policy design, along with putting forward their voices publicly instead of those of think tank leaders or politicians, serves to shift racist and sexist narratives that have guided much of our nation's policy creation for far too long. It also helps recipients to change their own visions of themselves, and for the first time be encouraged to dream, hope, and plan for a future they previously thought impossible.

Too often, policy is created with a strictly transactional approach. This fails to take into account the many ways in which policies shape how marginalized groups like poor Black women see themselves.

Stories from the women who have taken part in the program illustrate the tremendous value in policy that is paired with empathy in programs such as MMT.

Elsie¹⁴

Elsie, a mother of two, describes how taking part in the first round of the program still affects her years later: "I was in the very first round of the Magnolia Mother's Trust, which started three years ago. So it's been about two years since I stopped getting the guaranteed income payments, but the program allowed me to do so much that's still benefiting me now. I was able to move out of subsidized housing and into my own place; I was able to get a more reliable car; I did a little traveling with my kids — it allowed me to be able to provide better for them. My experience with the Trust taught me a lot: patience, improving my budgeting, focus."

I'esha¹⁵

I'esha was able to use the expanded CTC and her guaranteed income to pay her bills after a high-risk pregnancy forced her to quit a job that had her on her feet all day as a hotel cleaning supervisor. She offered her hope that national leaders will offer long-term solutions to support families like hers: "If I could talk to President Biden, I would tell him that he should make the child tax credit permanent, because so many people are still unemployed and the pandemic is not over. And people need help even without a pandemic going on. I would love to see a program like the Magnolia Mother's Trust offered to more people, too. The government should want to pitch in a little more to help with programs like guaranteed income to help more families."

Sherika¹⁶

Sherika, who received both a guaranteed income and the expanded CTC, explains the transformative benefits of the paired programs: "Being part of the Magnolia Mother's Trust has really lifted a burden off my shoulders as a mom. Before, I would have to scrape together the money or ask for help from family to be able to do simple things like buy school supplies. But this year, since I was part of the program, I was able to go school shopping early. I've already started doing a little Christmas shopping. Before the program, I wouldn't have ever been able to do that. And with the Trust on top of the child tax credit that's been coming monthly, it's been so necessary for me. One helps me pay my bills; the other helps me put away a little bit for the hard times. I know that Congress and the president are deciding whether they are going to keep it going, and I really hope they do. If it weren't for those payments, I wouldn't have been able to take a little time off to care for my baby. I really don't know what I would have done. These two things combined have done so much for me and my family; it has just uplifted me a lot and I'm very grateful."

Chephirah¹⁷

Chephirah spoke about how the money both allowed her to cover her bills and enjoy quality time with her daughter: “The money has also helped me cover my monthly bills and get caught up on some old debts. It also helps to pay for things like my daughter’s schoolbooks. And then she wanted to have a dinner for her birthday, and I wouldn’t have had the ability to pay for that before the program. But with the Magnolia money and my dad helping out, I was able to do that, and have everyone come out and show love to her. The dinner and a trip down to New Orleans were the two things she asked for, for her birthday, and I was able to do both because of that help of the program and my family. We just got back from New Orleans, which was the first time either of us had been there. I think that’s probably the first time we’ve been able to take a trip as a family in at least seven years. It’s been a long, long time since we had a little vacation.”

Johnnie¹⁸

Johnnie was able to use her guaranteed income to cover her bills when schools went fully remote and she had no one to look after her young daughter; it ensured that her daughter was able to take part in online schooling: “During the pandemic, it was really hard for me because it was mandatory for me to go to work, but then my daughter was home from school and I didn’t have anyone to be there to help her. I also didn’t have internet at home, so I had to pay to get that so that she could do her schoolwork online. It was really a struggle for both of us — it was hard for her to learn from a computer, and I had to put in the extra time to try and teach her between work. I ended up leaving my job because it was not safe and my daughter was not able to continue with school without my help. If I could’ve had somewhere to take her where she could get help with her online school, then that would’ve allowed me to keep my job. But I didn’t have any options, so I had to quit my job to help my baby.”

Sabrina¹⁹

Sabrina’s highlights from the program ranged from saving money to pay for her college classes to being able to afford a birthday party for her son for the first time in years: “Being in the program has helped out a lot. When I got my first check, it was both my and my son’s birthdays. We were able to do things we haven’t been able to do in other years — he had a party at a trampoline place with lunch. I haven’t been able to afford to throw him a party in the last few years. And then my birthday is a couple days after his, and I had a birthday dinner and am planning a little trip next month. I have plans for what to do with the money throughout the year — I want to go back to school. And I’ll need to pay off what I owe to school before I can go back. I was paying out of pocket because my financial aid got messed up, so I still have a balance there at the community college. It’s about \$800, so I’ll need to save up for that. But once I pay it off, I can go back, and then I can get my financial aid sorted so I won’t have to keep paying out of pocket for my tuition.”

Nikki²⁰

Nikki suffers from sickle cell anemia, which has left her unable to work but still needing to provide for her two kids. The MMT money gave her the resources to cover her bills so that she can focus on her health. “I have three different kinds of pain medications I take on a daily basis. I’m really careful about the meds, because a lot of people with sickle cell end up addicted to pain meds. And I can’t let that happen; I’ve got two kids to take care of. But the pain — oh my goodness, it is so intense. It is something I wouldn’t wish on my worst enemy. Some nights the pain is so bad I cry myself to sleep...It has left me disabled, so I can’t work. I’m in and out of the hospital, especially during the wintertime. There’s something about the cold and also the rain that makes it worse for me, and it’s one of those things where the older you get the worse it gets. So with me being 42, it hits me really hard.”

Annette²¹

Mother of two Annette used her MMT funds and CTC payments to pay for her kids’ uniforms and her own school tuition. “Because I work in a school, I don’t get paid in the summer when we’re off. So that makes it really hard to make ends meet. Thanks to the new child tax credit expansion coming monthly and the Magnolia Mother’s Trust, I’ve been able to do more for my kids and not have to worry if I can afford a school uniform or school supplies. I’ve also been able to catch up on some bills. I don’t make much at my job; it’s really more important for the benefits. If I were able to sit down with our country’s leaders, I would tell them how important a program like the trust is. It helps low-income women like myself better ourselves. The money has helped me in pursuing a better future for me and my kids and allows me to do things that I wasn’t really able to before — like going back to school, since I have to pay for that myself...For me, my goal right now is to finish school. It makes me feel hopeful because I know if I finish school, I will be a better person, and I’ll be a better person for my kids. Sometimes my son will ask me why I didn’t go to college, and I’ll tell him I did go, I just didn’t finish. So I’m showing him that it’s never too late; no matter how old you are, you can still go back and do what you were meant to do.”

As the stories of MMT make clear, needs are individual, but cash is universal. Guaranteed income is not a panacea for the many ways in which our systems are designed to fail Black women and their kids in particular, but it does offer a flexible, effective, and swift way to alleviate economic anxiety and build financial resilience.

It allows recipients to exist as their full selves instead of only as a vehicle to maximize paid labor.

It affords them the invaluable opportunity to recognize that they are good caretakers and that the blame for the failure to support families in this country falls squarely at the feet of policymakers, not parents.

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Lifting Children Out of Poverty Takes More Than Access to Government Programs; It Demands Focus on User Experience

Julieta Cuéllar, Propel

Samantha is the mother of two children — an 11-year-old and a 15-year-old — living in Birmingham, Alabama. She filed her 2020 taxes in February 2021 with a local tax preparer. But she didn't receive her tax refund for another seven months — until September — and only after she'd called the IRS so much that she was referred to a tax advocate. She also had to fill out a form to reinstate her children — "I guess [to prove] that they're mine." The tax advocate told Samantha that she'd definitely start getting the monthly advance Child Tax Credit (advCTC) payments by October. But October came and went and, as Samantha said, "Now it's hard to get in touch with the tax advocate." By late December, she had not received a single advCTC payment. She still called the IRS frequently, but now, according to Samantha, "They send me to this Child Tax Credit line, and the person who answers the phone tells me not to give them any personal information. They're just there for general information. That's no help to me if you can't pull up my information to see why I haven't gotten [it]." Samantha also checked the Child Tax Credit update portal daily, but could only see that her eligibility was "pending." Two days before Christmas, Samantha was fulfilling DoorDash orders, because she hadn't yet gotten her kids' Christmas gifts. Fighting back tears, she said, "I thought I would get all of my tax credit [in] December, and that didn't happen. So I'm kind of desperate."

In 2020, 9.7% of children in the United States lived in poverty. Despite a devastating economic downturn precipitated by the COVID-19 pandemic, this was a 23% decrease from 2019. New assistance, such as the Economic Impact Payments (stimulus payments), and expansion of existing programs, such as SNAP (Supplemental Nutrition Assistance Program, or "food stamps"), lifted millions of children out of poverty.² In 2021, child poverty was slashed even more dramatically, thanks to the expanded Child Tax Credit, which for the first time was extended to all low-income households with children, even those without any earned income. What's more, half of the Child Tax Credit was distributed automatically by the Internal Revenue Service (IRS) in advance monthly payments from July to December 2021.

However, the experience of receiving the advance payments was anything but automatic for many low-income families. Low-income families were less likely to have filed taxes consistently or recently, as doing so is not required below a certain threshold of earned income, and because filing taxes can be costly for the majority of households, who go to paid preparers. Even if low-income families had filed taxes recently, they did not necessarily have direct deposit information on file to receive the advance payments in a timely manner. And then there were thousands like Samantha, whose tax return got caught up in bureaucratic red tape, leaving her for months without assistance she was eligible to receive.

The lesson of the advCTC payments, which have ended for the time being, is then twofold: we have the ability to slash child poverty dramatically through existing infrastructure, and this infrastructure is not set up to serve the most low-income children. But access to government programs — be they the Child Tax Credit advance payments or SNAP — is only part of the solution. **The experience of receiving government benefits is as important as getting access to them.** We've learned this through our work at Propel in helping to modernize the SNAP experience through technology.

Initially, Propel focused on improving the elaborate SNAP application process. But ultimately, Propel hit on a unique and pressing need among the vast majority of SNAP users — being able to easily check their benefits balance at any time, in this case through a smartphone app called Providers. This improvement to the experience of receiving SNAP benefits is of such value that an estimated one in four SNAP recipients currently uses the Providers app.

Today, the Providers app helps low-income households gain access to and manage all their sources of income in one place by offering EBT card³ balance checking and a free debit card, offers to save on food and other necessities, and opportunities to apply for jobs. The Child Tax Credit expansion provided a real-time opportunity to observe and address challenges in accessing benefits and to improve the experience of receiving benefits.

What We've Learned about User Experience from SNAP

Ayisha is from South Alabama, “the hardest spot on the map to see,” as she puts it. She has three kids under the age of six. She first heard about Providers through her caseworker — well, her second caseworker. “My old caseworker pretty much just said, ‘Here’s your EBT card. Have a great day.’” The day Ayisha got her Providers app, she called her 70-year-old mother (“she’s like my best friend”) and walked her through the process of downloading it as well. “She needs something easier than an automated [phone] system to get her balance,” Ayisha said. The last time Ayisha looked at the app was this morning, while going through her phone after the baby woke her up for a feeding. She’d given her fiancé the EBT card to go shopping the day before, but had never asked him how much he spent. She’s not concerned, really, except that she wants to know how much is left before she goes shopping again. “I don’t want to get to the cashier with \$200 worth of groceries and have \$170 to cover it,” she said. She’s been at the store with a whole basket of groceries and then checked her balance. “You’re praying and you’re hoping that you have enough,” she said. Now Ayisha always has her groceries tallied up — within a dollar range, since the taxes aren’t included in the listed prices. Better to know in advance how much she has on the EBT card, she said, and then double-check once she’s in line.⁴

In 2020, SNAP lifted 1.1 million children out of poverty. But Ayisha’s story demonstrates how getting on a program like SNAP is just the first step in alleviating poverty. Like millions of other low-income Americans, Ayisha has faced the indignity of reaching the cashier at the grocery store, only to realize she didn’t have enough money on her EBT card to cover the food in her cart. Most SNAP benefit amounts are insufficient to cover a household’s entire food needs. In fact, on average, households spend more than half of their monthly SNAP allotment within the first week of receipt.⁵

In 2015 Propel launched the Fresh EBT (now called Providers) app. The Providers app allows EBT cardholders to view their SNAP balance at any time, in addition to helping them manage their benefits through tracking transactions, saving via coupons, and earning money through working. Providers is available for free in all 50 states and has grown to reach more than 5 million people every month. In 2021, Propel began offering a free debit card, making Providers the only place where households can view EBT benefits and cash side by side.

Prior to the Providers app, SNAP recipients had to call a toll-free number, go through an automated phone system, and enter their 19-digit EBT card number in order to hear their EBT card balance. Despite the inconvenience of the phone call method, Propel found during early research that this is likely the most called number in the country. Because Providers makes it easier, households can now check their EBT balance more frequently, often before and after every shopping trip, as Ayisha does. And as a result, benefits last longer. Research conducted since Providers launched found that the app helps users extend the length of time their benefits last.⁶ Even just making benefits last one or two more days is impactful when 80% of users spend their benefits within nine days.⁷

The COVID-19 pandemic brought new challenges to the social safety net experience. The federal government spent record-breaking amounts on nutritional assistance, bringing much-needed aid to the millions who were left without work or were sick. However, the impact of this assistance was limited by its unpredictability.

All states began to issue emergency allotments of SNAP benefits in spring 2020. Then, at the beginning of 2021, households also began receiving a 15% increase in SNAP's maximum benefit. Finally, a new program, P-EBT, provided food benefits to replace free or reduced-price meals children would otherwise have received at school. Payments suddenly hit EBT cards, sometimes with each part (regular SNAP amount, maximum allotment, and 15% increase) arriving separately. P-EBT payments arrived on new, separate cards in some places, and on existing SNAP EBT cards in others. P-EBT payments also arrived much later than the time period they were intended for. The State of Georgia, for example, began issuing P-EBT payments meant for August–October 2020 in August 2021. In addition, P-EBT benefit amounts were calculated differently by state, and even by county, based on the number of days children were learning virtually, making it extremely difficult for households to check the accuracy of their payments or know the amount to expect.

Of the Providers users interviewed for this chapter, 30% said they did not know what or how much they would get each month on their EBT cards, and 17% said they worried about having to pay back the extra deposits they received beyond their usual SNAP amount. This had concrete consequences that limited the impact of this aid; 38% of users said that not knowing how much to expect each month made it harder to plan ahead, 29% said they struggled to pay their other monthly bills, and 19% said they were afraid to spend extra benefits.

Propel quickly recognized the information void that SNAP recipients were experiencing and launched a new feature in the Providers app called the Benefits Hub. The Benefits Hub aggregates publicly available information to give users the latest information on SNAP and P-EBT benefits, by state, as well as information on unemployment insurance, rental assistance, and a number of other benefits.

Accessing and Receiving the Expanded Child Tax Credit

Todd is a married father of three girls. He and his wife are disabled and in the process of applying for disability benefits. His wife is sometimes able to work but has multiple mental disabilities. Their only steady source of income is their daughter's disability benefits. For Todd, the first two months of receiving the advCTC payments was "absolute bliss...I was able to pay all bills, pay for kids' clothes, spoil my wife." But in mid-September, when he should have received the third advance payment, he received nothing. "I started freaking out," he said. This missing Child Tax Credit payment coincided with a custody battle with his sister, caused him and his wife to lose their daughter's disability benefits. Todd was suddenly left with no income. He lost his wife's bike because he couldn't make the payment, and he almost lost his couch, which he was also renting to own. He went most of the month without car insurance as well. Todd called the IRS at least five times," he said, and checked the portal every morning. "All these other platforms I use work, but the IRS's [platform] doesn't," he said. Finally, toward the end of the month, he received a partial payment from the IRS — only \$500 instead of the \$800 he had been receiving — and he had no idea why.⁸

The American Rescue Plan Act (ARPA), enacted in March 2021, transformed the Child Tax Credit into a near-universal monthly cash transfer for families with children under 18. Previously, the Child Tax Credit was delivered in a lump sum as part of a tax refund and excluded low-income families who did not earn enough, or any, income.⁹ ARPA also increased the maximum credit per child and expanded it to include 17-year-olds. The result was monthly payments of \$250 (for children 6 to 17 years old) and \$300 (for children 0 to 5 years old) for all families with earnings under \$112,500, if single parents, and \$150,000, if married couples.

This provision was historic in its reach, flexibility, and delivery. However, the federal government had a mere four months to make the advCTC payments a reality. The IRS, which was suddenly tasked with setting up monthly payments to the vast majority of people with children under 18, was already grappling with an extensive backlog of tax returns, due to the extended deadline to file 2019 taxes, as well as with challenges in Economic Impact Payment ("stimulus payments") distribution.

The advCTC payments featured both extensive access and experience problems for low-income recipients. In terms of accessing the payments, the most obvious challenge was serving the millions of low-income households that irregularly or never filed taxes. (The IRS drew from 2020 tax filing data, and if necessary, 2019 tax filing data, to send out advCTC payments.)

Tax filing is required only for those who earn more than the standard deduction for their filing class, which ranges from \$18,800 for heads of household to \$25,100 for married couples. Among the more than three million Providers app users with children under 18, an estimated 22% had no earned income and about 56% earned less than \$12,000 annually. We conducted interviews and research among users who irregularly or never file taxes, and we found that most knew they were not required to file and considered filing taxes expensive, stressful, and downright risky if they were to get something wrong.¹⁰

To address the population of eligible recipients who had not filed 2020 or 2019 taxes, the IRS created a “Child Tax Credit Non-filer Sign-Up Tool.” Households would file a simplified tax return via this online tool in order to receive the monthly advCTC payments. However, as the payments began to go out to households in July 2021, Propel and other low-income-facing organizations began to notice that many eligible households that had filed 2019 or 2020 taxes were not receiving the payments.

It appears that a few factors may have contributed to so many eligible households not receiving payments, despite taking all the necessary steps. First, a substantial group of households knew or suspected that someone else was receiving their child’s advCTC payment. It also appears that amending a tax return substantially delayed processing, as did committing any kind of error that kicked a return to the manual return backlog — errors that included incorrectly inputting the amount received in Economic Impact payments.¹¹ Finally, we have preliminary evidence that the IRS took a substantial amount of time to process returns received through the sign-up tool for non-filers. Still, many families, like Samantha’s, had no idea why they hadn’t received payments.

Many households that did automatically start receiving the advCTC payments in July 2021 also faced difficulties. Nearly every month of the advCTC payments was plagued by some kind of error. In July, some taxpayers who filed with an ITIN¹² received both July and August payments in August. In August, some taxpayers received the advCTC payment by mailed check, even if they had direct deposit information on file, and in September, some families, like Todd’s, experienced a delay for undisclosed reasons.¹³

The IRS had launched a tool that could help families manage their advCTC payments — the Child Tax Credit Update Portal. The portal allowed taxpayers to check the status of their payments and update payment information. The portal could have ameliorated the impact of payment errors, but it was difficult to access due to onerous identification verification requirements. Of the Providers app users interviewed, 38% reported having some type of problem accessing the Child Tax Credit Update Portal.¹⁴

These errors and issues with online tools were to be expected, given the short time frame the IRS had to roll out the advCTC payments. While these missteps may seem small for an agency that moves billions of dollars annually, they had real implications for advCTC-eligible families. Higher-income families can better absorb the loss of one advCTC payment that got sent to the wrong address, or wait to claim the whole Child Tax Credit in their next tax return. But for families like Todd’s, a small delay can lead to a financial catastrophe. So if there are limited resources and time to stand up a new benefit distribution system, the needs of low-income families should be given priority.

In an effort to relieve the various access and experience issues in real time, Propel created a Child Tax Credit wizard in the Providers app to direct users to the best resource. Users answered a few questions and were led to the non-filer portal (if they had not filed taxes), to the update portal, or to more information on eligibility. The in-app Benefits Hub also informed users of any errors or delays that may have affected their advCTC payments in a given month.

How Else Can User Experience-Focused Technology Assist Children in Poverty?

If we're to make good on our efforts to ensure that all children have their basic needs met through the social safety net, we must continue to cast a critical eye on how assistance programs are experienced by their beneficiaries. SNAP and the advCTC payments are large programs that lift millions of children out of poverty. But there are plenty of other programs that should also be improved.

For example, the experience of filing taxes and receiving tax benefits remains a huge challenge, regardless of whether the Child Tax Credit continues to be distributed on a monthly basis. Low-income families pay exorbitant amounts for tax preparation — on average, Earned Income Tax Credit-eligible taxpayers pay \$400 to file their taxes — and face a high error rate on their returns.¹⁵ In addition to widespread errors made by tax preparers, EITC claimants are also disproportionately targeted for audits by the IRS.¹⁶ Finally, millions of households fail to claim the credits they are entitled to.¹⁷

Each tax season provides an opportunity both to address these issues and to commit the same mistake, giving awareness and access an outsized priority while neglecting the seemingly small experiential elements that can make or break low-income households. The same goes for any other future efforts to strengthen the social safety net for children and their families.

1. Real Providers user interview; name has been changed.
2. Cara Baldari, "Fact Sheet: Child Poverty in the Wake of COVID-19," First Focus Campaign for Children, November 23, 2021, <https://campaignforchildren.org/resources/fact-sheet/fact-sheet-child-poverty-in-the-wake-of-covid-19/>.
3. EBT (Electronic Benefits Transfer) cards are used to distribute SNAP benefits, as well as other benefits like WIC (the Women, Infants, and Children program) and TANF (Temporary Assistance for Needy Families, or cash welfare).
4. Real Providers user interview; name has been changed.
5. "SNAP Helps Struggling Families Put Food on the Table," Center for Budget and Policy Priorities, November 7, 2019, https://www.cbpp.org/research/food-assistance/chart-book-snap-helps-struggling-families-put-food-on-the-table#_edn10.
6. Hillis, Andrew, "Salience through Information Technology: The Effect of Balance Availability on the Smoothing of SNAP Benefits," Harvard Business School Working Paper No. 18-038, October 2017, <https://www.hbs.edu/faculty/Pages/download.aspx?name=18-038.pdf>.
7. De la Rosa, Wendy, and Joanne Yeh, "Managing SNAP (Food Stamps) Efficiently," Center for Advanced Hindsight, 2016, https://advanced-hindsight.com/archive/wp-content/uploads/2015/11/propel_case.pdf.
8. Real Providers user interview; name has been changed.
9. Under ARPA, the Child Tax Credit went from partially to fully refundable, meaning that all of the credit could be received as a refund instead of only being applied to taxes owed. Many low-income families did not previously benefit from the Child Tax Credit because they did not have any earned income, and therefore could not claim the credit at all, or did not earn enough to owe taxes, and therefore only received the portion of the credit that was refundable.
10. Read more on our findings here: <https://www.joinpropel.com/child-tax-credit-potential-impact>.
11. Many households were also filing taxes on unemployment benefits income for the first time and under new or changing IRS rules, which also led to errors. There may also have been other factors that led to a manual review by the IRS, such as not regularly filing taxes, which the IRS can automatically look back on to immediately resolve errors.
12. ITIN stands for Individual Taxpayer Identification Number and is used by those who do not have a Social Security Number.
13. The addresses on file were not necessarily accurate, resulting in lost payments.
14. They had two options for accessing the portal: use or create an IRS account (which required having either a student loan, a mortgage, or a credit card) or an ID.me account. Since only 32% of Providers users had a student loan, mortgage, or credit card, most had to create an ID.me account. ID.me requires individuals to photograph a form of identification and take a selfie, and then uses image-matching technology to "verify" their identities. Among Providers users who attempted to access the online portal, 20% reported having a problem with ID.me, including not having the correct documentation, the facial recognition technology not recognizing them, their photos being too poor in quality to be accepted, and not being able to upload the photo of their identification. Challenges with ID.me's verification system have been documented broadly elsewhere.
15. Weinstein, Jr., Paul, and Bethany Patten, "The Price of Paying Taxes II: How paid tax preparer fees are diminishing the Earned Income Tax Credit (EITC)," Progressive Policy Institute, April 2016, https://www.progressivepolicy.org/wp-content/uploads/2016/04/2016.04-Weinstein_Patten_The-Price-of-Paying-Taxes-II.pdf.
16. Kiel, Paul, and Jesse Eisinger, "Who's More Likely to Be Audited: A Person Making \$20,000 — or \$400,000?," ProPublica, December 12, 2018, <https://www.propublica.org/article/earned-income-tax-credit-irs-audit-working-poor>.
17. About 22% of eligible taxpayers did not claim the EITC in tax year 2018, for example. "EITC Participation Rate by States Tax Years 2011 through 2018," Internal Revenue Service, December 6, 2021, <https://www.eitc.irs.gov/eitc-central/participation-rate/eitc-participation-rate-by-states>.

Undoing the Racist Legacy of Cash Assistance in the South

Reimagining TANF Using the “Black Women Best” Framework

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Forward

This report was written before the Supreme Court overturned the constitutional right to abortion in *Dobbs v. Jackson Whole Women’s Health*. Many of the same states whose cash assistance policies this report describes as reflecting racist and sexist policy histories are also those that have banned or severely restricted abortion access or are trying to do so. These new restrictions, legal and financial, will fall hardest on the people with the fewest resources — disproportionately people of color, immigrants, and others who have historically been marginalized. They will face the highest hurdles to overcoming state-level restrictions due to this nation’s long history of racism and discrimination. In states with serious restrictions to abortion access, people who are pregnant will have less personal autonomy. Many people who have low incomes, little savings, inflexible jobs, or child care responsibilities will face enormous obstacles, financial and otherwise, if they decide to seek abortion care in another state or if they are compelled to carry pregnancies to term that they would have chosen to terminate if abortion was accessible in their communities.

Being denied abortion harms families’ long-term financial well-being, the groundbreaking Turn Away Study has found.¹ Women — the study did not include trans men and non-binary people seeking abortions — who were denied an abortion because they were past a state’s gestational limit were four times as likely to have incomes below the poverty line and are less likely to be able to afford basic necessities like food and housing.

All people should be able to decide whether or not to have children and to have those decisions supported by public policies that equip them to succeed. This includes both ready and affordable access to abortion care for those who make the decision to terminate their pregnancies and adequate supports for families with low incomes who decide to carry their pregnancies to term. For those who choose to have children, monthly cash assistance and employment supports, both of which Temporary Assistance for Needy Families (TANF) is supposed to provide, should be available and robust enough to support families and children. However, as this report illustrates, TANF — rooted in more than a century of racism and sexism, primarily targeted at Black women but with harmful effects for all families with children who need help — falls far short of what families need.

Many of the same analysts and policymakers who have championed these racist TANF policies are also behind policies to restrict abortion access. Already, abortion is either completely banned or severely restricted in Alabama, Arkansas, Georgia, Idaho, Louisiana, Kentucky, Missouri, Mississippi, Ohio, Oklahoma, South Dakota, Tennessee, and Texas, and more states are expected to follow suit.² In most of these states, TANF reaches fewer than 10 out of every 100 families living in poverty and provides a maximum benefit level below 20% of the poverty line.

With more families likely to need financial assistance due to abortion bans, whether or not TANF meets this need will be another chapter in a longer story of cash programs’ interaction with Black and unmarried women’s reproductive lives. Under TANF’s predecessor, Aid to Families with Dependent Children (AFDC), states instituted “suitable home” policies that denied assistance to families with a child born to an unwed mother and searched the homes of recipient families for any man living in the home under suspicion that they were a father or “substitute” father not providing for the children. Several states considered (but did not implement) sterilization of unwed mothers

on AFDC and, later, birth control requirements as a condition for AFDC receipt. In the 1990s, almost half of U.S. states adopted family cap policies, which deny families more cash assistance when they have another child while receiving TANF. Family cap policies still exist in 11 states, a majority of which have restricted or banned abortion. Many of these policies targeted Black and unmarried mothers or were enacted in states with high Black populations.

Providing access to the full range of reproductive health services, including abortion, and ensuring that families have the support they need to meet their basic needs are fundamental for achieving reproductive justice. While some who celebrate the Dobbs decision have proposed strengthening economic support programs, including TANF, doing so is not a substitute for abortion access and bodily autonomy.

As the Reproductive Justice framework,³ developed by a group of Black women in 1994, illustrates, access to reproductive health services including abortion and economic support programs like TANF are complementary to each other: together, both sets of policies provide people with dignity and autonomy over their bodies and lives by enabling them to make the decisions best for themselves and their families.

1. Advancing New Standards in Reproductive Health, “Turn Away Study,” Bixby Center for Global Reproductive Health, University of California San Francisco, https://www.ansirh.org/sites/default/files/publications/files/turnaway_study_brief_web.pdf.
2. This reflects the abortion policy as of August 25, 2022. More states are likely to ban or severely restrict abortion in the coming months. For a regularly updated overview of states, see Guttmacher Institute, “Interactive Map: US Abortion Policies and Access After Roe,” updated August 25, 2022, <https://states.guttmacher.org/policies/indiana/abortion-policies>.
3. Sister Song: Women of Color Reproductive Justice Collective, “Reproductive Justice,” <https://www.sistersong.net/reproductive-justice>.

Undoing the Racist Legacy of Cash Assistance in the South: Reimagining TANF Using the “Black Women Best” Framework

Economic security programs can help families meet basic needs and improve their lives, but design features influenced by anti-Black racism and sexism have created an inadequate system of support that particularly harms Black families and other families of color. This is especially true in the South, which has a long legacy of denying or providing limited cash support to families in need. Temporary Assistance for Needy Families (TANF), the nation's primary program for providing cash assistance to families with children when parents are out of work or have very low income, is perhaps the clearest example of a program whose history is steeped in racist ideas and policies that particularly strip Black women of their dignity. Those policies do not solely harm Black families; they harm all families. If TANF programs remain in their current diminished state, millions of children — disproportionately Black children — will be left behind to experience the detrimental impacts of poverty.

A large and growing body of research shows that experiencing poverty and hardship, even briefly, can have detrimental, lifelong impacts on children. Researchers have linked stress caused by a scarcity of resources to long-lasting negative consequences for children's brain development and physical health.¹ People who experience poverty in childhood have lower levels of educational attainment, lower earnings, higher likelihood of being arrested, and poorer health in adulthood, a 2019 National Academies of Science, Engineering, and Medicine report found.²

Congress created TANF in 1996 to replace Aid to Families with Dependent Children (AFDC), purportedly to help families lift themselves out of poverty through work. But much of the debate around the 1996 law was centered (often implicitly, but sometimes explicitly) on criticisms of Black mothers,³ who were portrayed as needing a “stick” to compel them to be more responsible and leave the program. TANF's harsh work requirements and arbitrary time limits disproportionately cut off Black families and other families of color. Also, Black children are more likely than white children to live in states where TANF has the lowest benefits and reaches the fewest families in poverty. In the decade after policymakers remade the cash assistance system, it became much less effective at protecting children from deep poverty — that is, at lifting their incomes above half of the poverty line, a little more than \$900 a month for a family of three — and children's deep poverty rose, particularly among Black and Hispanic children.⁴

Many of TANF's rules mirror those dating back to cash programs of the early 20th century, and many of its assumptions reflect anti-Black racism dating back to enslavement. Throughout the history of cash assistance, many policymakers and public figures have used these same racist justifications and stereotypes to question Black women's reproductive choices; coerce Black women to work in exploitative conditions; and control, deride, and punish Black women who receive cash assistance. TANF's design perpetuated these attitudes and, in some ways, reinforced them, such as through stricter work requirements and expanded state control over program rules.

This paper, an abridged version of a report published by the Center on Budget and Policy Priorities in August 2021,⁵ applies the “Black Women Best” framework to reimagining TANF. Developed by Janelle Jones, former chief economist at the Department of Labor, the framework “argues if Black women — who, since our nation’s founding, have been among the most excluded and exploited by the rules that structure our society — can one day thrive in the economy, then it must finally be working for everyone.”⁶ Consistent with Jones’ framework, redesigning TANF so that it centers the needs of Black women and families would better serve families of all races and ethnicities by adequately helping families struggling to afford the basics and offering meaningful opportunities to gain skills and secure quality jobs.

This paper focuses on the South, where many of the policies and trends discussed originated and are often most harmful. Children and their families in Southern states face higher levels of poverty and economic hardship than those in other states. Four in 10 of the nation’s children who experience poverty live in the South (as defined by the U.S. Census Bureau), a higher share than the Midwest, Northeast, or West.⁷ Furthermore, 58% of the nation’s Black children who experience poverty live in the South, as do 43% of white children, 41% of Hispanic children, and 26% of Asian children who experience poverty.⁸ However, state policymakers in the South have largely chosen not to use the policy levers available to reduce the extent and severity of child poverty. The South has weaker labor and social support policies and programs than other regions, a recent report from the Center for American Progress finds. TANF is a prominent example: TANF programs in nearly all Southern states rank among the least generous and most restrictive in the nation.⁹

TANF Benefits Too Low to Support Families, Especially in the South

States’ long-standing control over benefit levels in cash assistance programs set the course for the large geographic and racial disparities in TANF today. As Congress debated the Social Security Act of 1935, which created the Aid to Dependent Children (ADC) program (later renamed Aid to Families with Dependent Children, or AFDC), initial proposals to ensure adequate benefits across the country were undermined by a then-powerful Southern congressional bloc, which insisted on state and local control over the program.¹⁰ Later attempts to establish a minimum federal benefit for AFDC similarly failed in Congress. The defeat of these and other proposals to make cash assistance more adequate and accessible disproportionately harmed Black women and their families and, in turn, helped maintain racial discrimination and segregation in the economy — especially the Southern economy — by ensuring that AFDC did not compete with the extremely low wages paid to Black workers, who often were segregated into agricultural and domestic roles.¹¹

States employed different strategies to restrict access to benefits and to keep benefits low, and these efforts often disproportionately affected Black families. Between the mid-1930s and the early 1960s, state ADC/AFDC programs discriminated against Black families most visibly by preventing them from accessing the program in the first place. In the late 1930s and early 1940s, some states sought to prevent Black families from receiving ADC if mothers could work.

As a field report from the late 1930s explained:

There is hesitancy on the part of many [officials administering ADC in the South] to advance too rapidly over the thinking of their own communities, which see no reason why the employable Negro mother should not continue her usually sketchy seasonal labor or indefinite domestic service rather than receive a public assistance grant.¹²

As discussed below, “farm policies” coerced mothers to take low-paying jobs by reducing or ending benefits during harvest seasons, and behavioral restrictions attempted to block access to the program altogether. These policies often targeted Black families or arose in states with high concentrations of Black families.

With no federal standard for states to set benefits that met the needs of families, Southern states consistently attempted to keep benefits low. Twenty states set a maximum family grant irrespective of family size by 1958.¹³ Fifteen of them were in the South, a region that included half of the country’s Black population.¹⁴ The South was also home to the states with the lowest average ADC benefits in the country as of 1958: Alabama, Florida, Mississippi, South Carolina, and Texas. All five states were well below the national average (see *Table 1*).

Table 1: States in South Had Lowest Average Monthly ADC Benefits, 1958

State	Average benefit, 1958	Value of average 1958 benefit in 2021 dollars
Alabama	\$27.09	\$215.23
Mississippi	\$40.28	\$320.02
South Carolina	\$54.90	\$436.18
Florida	\$59.07	\$469.31
Texas	\$67.63	\$537.32
National	\$99.83	\$793.15

Source: Winifred Bell, *Aid to Dependent Children*

States maintained full authority to set benefit levels even after the federal government limited states’ ability to add eligibility conditions in the 1960s and 1970s, a move made to root out some particularly problematic eligibility restrictions some states, largely in the South, were imposing. Benefits quickly lost value during the 1970s due to high inflation, and while inflation later moderated, most states did not increase benefits enough to offset the decline.¹⁵ Between 1970 and 1996, maximum AFDC benefit levels lost more than 30% of their value in nearly every state, including every state in the South — a region that generally had lower benefits than the rest of the country when the 1970s began.¹⁶

Trends that started in ADC/AFDC have continued throughout TANF's 25-year history. TANF benefit levels tend to be lower in states where Black residents make up a greater share of the population, even after controlling for other factors, recent research finds.¹⁹ In 2021, 12 of the 16 states with maximum benefit levels below 20% of the federal poverty line were in the South, as were eight of the 16 states that have not increased benefits since TANF's creation.²⁰ In those 16 states, benefits have lost more than 40% of their purchasing power due to inflation. For a single-parent family of three, maximum benefit levels in the South range from \$204 in Arkansas (11% of poverty) to \$727 in Maryland (40% of poverty), with a median of \$303 (17% of poverty). Nationally, in comparison, the median maximum TANF benefit level is \$498 (27% of poverty), and benefit levels range as high as New Hampshire's \$1,098 (60% of poverty) (see *Figure 1*).

Despite Recent Increases, TANF Benefits Still Leave Families Well Below Federal Poverty Line

Maximum TANF benefit as percentage of poverty line (for a family of three), July 2021

Legend:

- 11-19%
- 20-29%
- 30-39%
- 40-60%

Note: TANF = Temporary Assistance for Needy Families. Federal poverty line for a family of three in 2021 is \$1,830 per month in the 48 contiguous states and the District of Columbia; Alaska and Hawaii have higher poverty lines.

Source: 2021 Health and Human Services Poverty Guidelines. TANF benefit levels for a single-parent family of three were compiled by CBPP from various sources and are current as of July 1, 2021.

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TANF Work Requirements Grew Out of Attempts to Control Black Women’s Labor

In the early days of ADC, states had free rein to impose eligibility policies designed to keep certain families off assistance. While these policies did not harm only Black families, they often targeted Black mothers or arose in areas with high concentrations of Black residents. Often these efforts were attempts to keep Black women in low-paid, exploitative jobs. While enslavement had ended decades earlier, the Southern economy remained reliant on cheap labor from a pool of vulnerable Black workers. Restrictive state eligibility policies made coercive jobs under white employers the only option for Black mothers to support their families. For example, a number of states imposed “farm policies,” which reduced or took away assistance for families during the harvest or planting season — often regardless of whether parents actually obtained employment. Louisiana’s 1943 farm policy denied assistance during the cotton-picking season to both newly applying families and those already receiving assistance, nearly all of whom were Black.²³ Similarly, Georgia implemented an “employable mother” policy in 1952 that barred families with earnings from receiving ADC benefits to supplement those earnings. These new rules severely constrained access to ADC in Georgia, disproportionately among Black families.²⁴

In the three decades that preceded TANF’s 1996 creation, efforts increased at the federal level to tie AFDC benefits to work. Between the late 1960s and early 1990s, work requirements grew to apply to more AFDC recipients and became more punitive.²⁵ One of the most consequential developments was the proliferation of “full-family” sanctions as the Clinton Administration granted waivers allowing states to take away benefits from the whole family, including the children, if a parent failed to meet work requirements.

Southern Democrats and other conservative policymakers pushed for these policies as public perceptions of AFDC recipients and people in poverty — two groups increasingly presented as Black in the media — grew more negative.²⁶ Some policymakers openly acknowledged that their objective was to continue coercing Black people into low-wage jobs. During the congressional debate over President Nixon’s proposed Family Assistance Plan (FAP), which would have replaced AFDC and provided dramatically more aid to Black Southerners, Representative Phillip Landrum of Georgia summarized Southern concerns about FAP by saying that “there’s not going to be anybody left to roll these wheelbarrows or press these shirts.”²⁷

Other racialized messaging was more subtle. Claiming that a “culture of poverty” existed in urban centers, conservative intellectuals such as Lawrence Mead and Charles Murray argued for policies that essentially would force low-income Black people to work, regardless of the quality or pay of the jobs available to them.²⁸ When AFDC caseloads reached record highs in the 1990s, racist arguments blaming Black people for their poverty underpinned some of the calls to “end welfare as we know it,” which became a central campaign pledge of both President Clinton, a Democrat, and congressional Republicans led by Representative Newt Gingrich of Georgia. When President Clinton signed the 1996 bill creating TANF, he claimed it “gives us a chance we haven’t had before to break the cycle of dependency that has existed for millions and millions of our fellow citizens, exiling them from the world of work,” ignoring the structural racism that limited Black women’s employment opportunities.²⁹

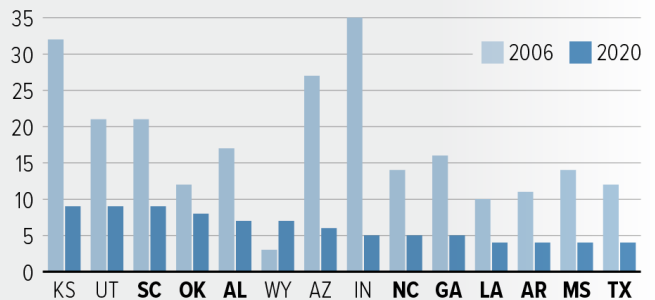
TANF conditioned receipt of cash assistance on work and granted states broad flexibility in creating their work policies and sanctions. States have used this flexibility to implement policies that restrict access to the program, including full-family sanctions and job search as a condition of eligibility. The 1996 law also set a lifetime limit of 60 months on receipt of federally funded benefits, and many states have opted for even shorter time limits, limiting access for many families.

Furthermore, TANF created financial incentives for states to reduce caseloads. Because of these and other changes, the number of families TANF serves out of every 100 families in poverty (known as the TANF-to-poverty ratio, or TPR) plummeted from 68 in 1996 to 21 in 2020.³⁰

Southern states, which had tended to serve fewer families in AFDC than the rest of the country, have seen access decline to record lows in TANF. Nine of the 15 Southern states had TPRs of 10 or less in 2020 (see Figure 2), and only Delaware and the District of Columbia had TPRs greater than 30. All Southern states have implemented full-family sanctions at some point since 1996, and all but two still take away a family’s whole benefit today.³¹

TANF Serves Hardly Any Families Living in Poverty in 14, Most Southern, States

Fourteen states had TANF-to-poverty ratios of 10 or less in 2020



Note: TANF = Temporary Assistance for Needy Families. TANF-to-poverty ratio measures the number of families receiving TANF benefits for every 100 families with children in poverty. Figures reflect two-year averages for 2005-06 and 2019-20.

Source: CBPP analysis of poverty data from the Current Population Survey and TANF caseload data from Department of Health and Human Services and (since September 2006) caseload data collected by CBPP from state agencies

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Figure 2

Policies that take assistance away when people don't meet a work requirement, which states have made more punitive over time, are a major driver of caseload decline in TANF. TANF programs primarily employ a “work first” approach, which aims to place recipients in jobs as quickly as possible. Such an approach furthers the occupational segregation of recipients, a majority of whom are Black or Hispanic, into low-quality jobs and reinforces the racist stereotype that parents receiving assistance will work only if coerced.

While employment that pays sufficient wages and provides regular hours can be a path from poverty toward financial stability, most TANF recipients are not on that path, a recent analysis of studies of parents leaving TANF shows. In Georgia, for example, 69% of parents who left TANF between 2009 and 2014 worked during their first year after exit, but only 34% were able to work consistently throughout the year,³² likely because a majority of parents worked in food service and other low-paying jobs that typically offer low job stability.³³ Moreover, only 9% of parents who left TANF earned enough in their first year after exit to lift their families above the poverty line.³⁴ Among a subsample of the Georgia leavers who participated in more in-depth interviews, 42% were food insecure and 25% experienced homelessness after leaving TANF.³⁵

Cash Assistance Policies Sought to Control Mothers’ Reproductive Decisions and Other Conduct

Instead of trusting parents to make the right decisions for their families, TANF is laden with undignified, coercive requirements designed to exclude people due to past conduct rather than current need, and in some cases even to control their reproductive decisions. Similar to work requirements, these policies send a message that parents seeking assistance are irresponsible, criminal, or otherwise undeserving of support.

Efforts to control Black women’s reproductive decisions and other conduct started under enslavement. Enslavers employed forced reproduction to control enslaved Black women while maximizing their economic returns by punishing them when they did not bear children.³⁶ Even after emancipation, many Black women did not have full control over their sexual and reproductive decisions. Black women and girls were systematically raped by white men in a parallel to the reign of terror in which thousands of Black people were lynched.³⁷ Cole Blease, governor of South Carolina from 1911 to 1915, pardoned both white and Black men convicted of raping Black women, stating, “I...have very serious doubt as to whether the crime of rape can be committed upon a negro.”³⁸

The narratives of promiscuity and irresponsibility that justified Black women’s exploitation under enslavement served as reasons for later cash assistance programs to deny aid to Black mothers. In the late 1940s and 1950s, when Black families and families with divorced or unmarried mothers made up growing proportions of the ADC caseload (as the numbers of white widowed families declined),³⁹ a number of states started passing laws aimed at “cleaning up” the caseload, as Georgia officials put it.⁴⁰

Several states, for example, imposed “suitable home” policies, which were ostensibly designed to protect children from maltreatment but allowed caseworkers and local administrators to deny aid based on moral determinations of a mother’s fitness for child-rearing. Some 23 states instituted formal suitable home policies, but the most punitive were in the South. These policies often targeted Black families, as these two examples show:

- Florida’s “suitable home” policy equated a mother having a child outside of marriage with child neglect; the family was therefore deemed unsuitable.⁴¹ Officials were likelier to scrutinize Black ADC families than white ones under this definition of neglect. The state threatened to remove children from the home if offending mothers did not release the children to extended family. Yet the state dropped the case if the family withdrew from the program, illustrating that the policy’s real purpose was to remove families from ADC, not to improve children’s well-being. Many families did not even apply to ADC for fear their children could be taken away.⁴²
- Louisiana’s 1960 “suitable home” law deemed a family “unsuitable” if it had “illegitimate” children, if the parents were in a common-law marriage (which was more common among Black families),⁴³ or if the mother was deemed “promiscuous.” Within three months, this law cut off more than 6,000 families (with about 23,000 children) from the program; 95% of the children in those families were Black.

Another set of policies aimed at controlling mothers' conduct was “substitute father” or “man-in-the-house” rules targeting mothers' personal relationships. These rules were based on the assumption that if a mother cohabited with a non-disabled man, he should provide financial support to the family even if he had no legal obligation to the child, had little or no income, or in the case of Michigan law, was simply a boarder.⁴⁴ These policies often targeted Black families as well. In Dallas County, Alabama, between 1964 and 1967, for example, 182 of the 186 families cut off due to this policy were Black.⁴⁵ Several states and localities, including many with high concentrations of Black residents,⁴⁶ created special surveillance units to watch mothers' homes and conducted unannounced home searches, sometimes called “midnight raids,” looking for evidence of a cohabitating man.

A small number of states even considered mandatory sterilization laws for ADC/AFDC recipients in the 1950s and 1960s. Often they cited Black mothers in particular; for example, Mississippi State Representative David H. Glass claimed that “The negro woman, because of child welfare assistance, [is] making it a business, in some cases of giving birth to illegitimate children.”⁴⁷ Lawmakers in Illinois, Iowa, Ohio, Tennessee, and Virginia proposed similar policies.⁴⁸ Although none of these sterilization proposals was passed into law, many states operated sterilization programs targeting people of color, people in poverty, people with mental illness, and others, some of which continued into the 1970s.⁴⁹

The 1960s and 1970s, a time of significant social change, brought an end to some of AFDC's most punitive behavioral control policies. Lawyers of the Welfare Rights Movement litigated for greater enforcement of federal eligibility standards and won key Supreme Court cases that ended some of the most harmful state eligibility rules discriminating against Black families and precluded states from restricting eligibility.⁵⁰ The Supreme Court rulings effectively ended many states' arbitrary eligibility policies and barred states from adding work or behavioral requirements or eligibility policies that were more restrictive than federal law. The 1960s and 1970s saw dramatic increases in AFDC rolls as more families could access and maintain benefits.

However, the racialized attacks on AFDC and its recipients mentioned above fueled efforts to reverse the federalization of AFDC, leading to the creation of TANF in 1996. In addition to work requirements, states imposed new behavioral requirements under TANF. While some of these policies have since been ended in many states, Southern states often make up the core of states where these policies are still in place:

- Family cap laws deny or limit an increase in cash assistance to families who have another child while enrolled in the program. Similar to earlier reproductive control measures, family caps punish single mothers receiving cash assistance for having additional children. New Jersey Assembly Member Wayne Bryant, who helped pave the way for the country's first family cap law in 1992, suggested Black women experiencing poverty could not be trusted with cash aid: “If parents are so irresponsible that they are unwilling to come to work or go to school, what makes you think they're taking the added welfare dollars and spending them responsibly on their kids?” he argued.⁵¹ Between the early 1990s and the early 2000s, 22 states enacted family caps. While half of them (most recently Connecticut) have since repealed their family caps, 11 states — including seven Southern states — still have not.⁵²

- In the 1980s, the federal government began restricting certain federal benefits for people convicted of drug-related crimes as part of its War on Drugs, which deeply damaged Black and brown communities.⁵³ Consistent with that approach, the 1996 law creating TANF barred people with felony drug convictions from receiving TANF benefits. However, the law allowed states to opt out of or modify the policy, and the number of states with a full lifetime TANF ban on people with drug felony convictions dropped from 23 states and D.C. in 1999⁵⁴ to seven states today; 26 states and D.C. have lifted the ban entirely.⁵⁵ Four of the seven states with full lifetime bans are in the South: Georgia, South Carolina, Texas, and West Virginia.
- While states can require drug tests as a condition of receiving TANF benefits, federal appellate courts have ruled that mandatory “suspicionless” testing is unconstitutional. A number of states have instead enacted suspicion-based drug testing laws. Thirteen states, including seven Southern states, currently have drug testing policies for TANF applicants and recipients.⁵⁶ Such policies not only presume participants’ guilt but also invoke racist stereotypes of Black people as criminals and drug users, even though Black and white people use drugs at roughly equal rates.⁵⁷ Drug testing policies rarely find people who test positive;⁵⁸ instead, they reduce TANF caseloads by creating barriers for applicants.

How Black Women Best Can Help Reimagine Federal TANF Changes

TANF provides little support to families in need — particularly in Southern states, which not only have historically instituted some of the most aggressive policies to exclude and punish Black and other mothers, but also have among the least generous, least accessible TANF programs. TANF programs in nine Southern states have benefits that are less than 20% of the poverty line *and* reach 10 or fewer families for every 100 in poverty: Alabama, Arkansas, Georgia, Louisiana, Mississippi, North Carolina, Oklahoma, South Carolina, and Texas. Four in 10 of the nation’s children who live in poverty, including six in 10 of Black children in poverty, live in the South, and most of those children are concentrated in those nine states with the weakest TANF programs (see Table 2). In the South, when parents lose a job or experience some other crisis, they have only limited access to cash supports, potentially exposing them and their children to the consequences of instability.⁵⁹

Table 2. Significant Shares of Poor Children Live in the South, Specifically in Southern States with the Weakest TANF Programs*

	All Children	Asian Children	Black Children	Hispanic Children	White Children
Share of U.S. children experiencing poverty who live in the South	44%	26%	58%	41%	43%
Share of U.S. children experiencing poverty who live in the nine states with the weakest TANF programs	30%	16%	40%	31%	28%

* Alabama, Arkansas, Georgia, Louisiana, Mississippi, North Carolina, Oklahoma, South Carolina, and Texas have TANF benefits below 20% of the poverty line and reach 10 or fewer families for every 100 families in poverty

Source: CBPP analysis of 2019 American Community Survey data.

Cash assistance for families experiencing a crisis needs to be a key component of our economic support system. Currently, TANF is the only source of monthly cash assistance for most families. (While efforts to improve the child tax credit, such as was temporarily done by the American Rescue Plan, are important, it likely won't be enough for some Black and other mothers with low incomes stemming from discrimination in the labor market, education, and housing.) TANF cash assistance must be fundamentally reimagined through a Black Women Best framework so that Black mothers have a program that provides stability through life's challenges, protects their children from hardship, and affirms parents' autonomy over their families and careers. When such a program is available to Black mothers, it will mean that we have crafted a TANF program that works well for all families facing significant economic distress.

As we see with TANF in the South, however, leaving that task up to the states means that many Black children will be left behind. Federal changes are essential to advance racial equity nationally and ensure a stable economic foundation for all families. Federal policymakers should reimagine TANF by doing the following:

- **Establishing a federal minimum benefit so that no family of any race falls below a certain income level.** A minimum federal benefit would establish a necessary floor to mitigate the large state-by-state disparities in TANF benefit levels and better protect Black, brown, and white families.
- **Barring states' mandatory work requirements.** Conditioning benefits on participation in mandatory work programs is one of TANF's most racially driven policies, one that started with enslavement and continued with coerced labor practices that continued long beyond emancipation. Federal policymakers should eliminate federal requirements that states take away benefits when adults don't meet a work requirement. Federal policymakers also should bar states from imposing their own sanctions for nonparticipation in work activities.
- **Barring behavioral requirements, time limits, and other eligibility exclusions.** Rooted in racism and sexism, these provisions demean families by assuming that adults are irresponsible and do not want what is best for their families.
- **Refocusing TANF agencies on helping families address immediate crises and improving long-term well-being.** Eliminating mandatory work requirements would free up resources within TANF that could be used to help families resolve crises and set and achieve long-term career, personal, and family goals. The families TANF serves (and those who are eligible but not receiving assistance because of restrictive policies) have diverse needs. TANF has an important role to play in helping families access resources within their communities that can help them improve their circumstances and in providing supports that will increase their chances of success.

- **Changing TANF’s funding structure to retarget TANF resources to basic assistance, address funding inequities, and prevent erosion over time.** States have used TANF resources to pay for other things beside cash aid to families. Federal policymakers should require states to spend a greater share of TANF resources on basic assistance and should also establish an equitable formula for allocating funds among states. (The current formula, based on state spending under AFDC, locked in low funding levels for states where Black children disproportionately live.) Federal policymakers also should increase TANF funds and index them to inflation to encourage states, especially those with lower benefits and higher Black populations, to increase benefits and serve more families.

Remaking cash assistance requires undoing the consequences — and power — of racist ideas and policies that have marginalized mothers and their families, Black families especially. A cash assistance program that centers equity for Black women would, as the Black Women Best framework posits, promote the economic security of all families with the lowest incomes.

Undoing the Racist Legacy of Cash Assistance in the South: Reimagining TANF Using the “Black Women Best” Framework

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Preventing Foster Care or Shifting the Burden?

The Urgent Need to Develop a Shared Understanding of Nonparental Family Types and the Child Welfare System's Role in Kinship Family Formation

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Introduction

As many as one in 20 children¹ in the United States lives in a household without either parent.² There is growing evidence that children living in nonparental care households have more challenges in childhood than children living with one or more parents,³ and this can be measured through Adverse Family Experiences (AFEs) and Adverse Childhood Experiences (ACES), with children in nonparental care being more than 30 times more likely to experience four or more AFEs than children with both parents.⁴ Given increasing evidence that adverse experiences in childhood have a dosage-like effect⁵ on both short- and long-term negative outcomes, research must move toward a more accurate understanding of the well-being of children in nonparental care.

To further understanding, the interaction between kinship care and the child welfare system (CWS) must be clear. Kinship care, which provides ameliorating effects after parental separation,^{6,7} is an option both inside and outside the CWS. There is compelling evidence that the intervention of foster care, on the whole, is not producing acceptable outcomes for children and their families. Unfortunately, there is a dearth of rigorous research on outcomes of children in the variety of nonparental care subgroups.⁸ Therefore, there is not sufficient evidence that kinship care outside the foster care system will produce different outcomes than our current status quo.

The paucity of research is partly due to the unavailability of administrative data on children in parts of the nonparental care population.⁹ Many are hidden from any formal system, such as the CWS.¹⁰ In addition, resistance to tracking the nonparental care subset of diverted kinship care adds to the problem.

As a result, the majority of information available on outcomes for children separated from their parents derives from ill-defined or broader subgroups of the population of children in nonparental care, focusing on such labels as “foster care,” “kinship care,” “formal kinship care,” and “informal kinship care.”¹¹ Anecdotal case studies of the success or failure of one type of nonparental care versus another are often used to support the arguments of individuals, organizations, and policymakers with a preexisting policy perspective regarding foster or kinship care in general.^{12,13} Continuing to enable prevailing terms like “informal kinship care” ignores the unique concerns of kinship families who have been diverted from the foster care system, stymies public discourse around improving outcomes for children, and prevents a more accurate understanding of the diverse living situations of children in nonparental care.

In research that has focused more appropriately on subgroups, notable differences based on the type of nonparental living arrangement emerge. For example, research shows that children in kinship foster care have the same or better outcomes in safety, stability, and well-being as children in traditional foster care.¹⁴ However, on other measures, such as academic performance and specific permanency outcomes, children in kinship foster care fare worse than children in traditional foster care.¹⁵ Research has also identified that unlicensed kinship care is less stable and less safe than both kinship foster care and traditional foster care.¹⁶ More recently, research has begun highlighting potential areas of concern for children who are living in voluntary kinship care.¹⁷

Only rigorous research with appropriate nonparental care population definitions will clarify under which conditions children fare the best, the most often. Two necessary conditions are required to improve research:

- Universal definitions of nonparental family types
- Mapping the role of the CWS in creating nonparental families

Progress must start with conscious definitions of nonparental care family types that are the same from jurisdiction to jurisdiction. Common definitions will assist in the development of a shared understanding of the mechanisms of nonparental family formation and their implications for the kinship triad of parent, child, and kin caregiver. Improved and consistent definitions will frame the data and research needed and provide a foundation for evidence-based kinship care practices.

Remedy also lies in developing a deeper understanding of the mechanics of nonparental family formation. This can be facilitated by developing a clear picture of how the CWS creates nonparental family types. This picture will show the family types, the pathway of formation, and the resulting access to parental reunification or alternative permanency options. A clear picture of family formation mechanisms will also uncover circumstances in which the child welfare agency may rely on kinship care as a cost- or time-saving strategy at the expense of the well-being of the kinship triad.

A shared understanding will provide a framework for dialogue between families and professionals across the county and assist in the thoughtful implementation of current policy such as the Families First Prevention Services Act. Speaking the same language will provide a baseline against which to measure success of current CWS policy and will ensure that future policy proposals around the use of kinship care more accurately address the needs of children and families.

Rethinking Nonparental Care Populations

The child welfare field should adhere to more specific terminology to ensure understanding between the communicator and the receiver regarding specific nonparental care subpopulations.

The first task to increasing shared understanding is the precise identification of subgroups within nonparental care.¹⁸ This identification should include a definition of the subgroups that can be translated across CWS jurisdictions and should consider the role of the child welfare agency in family formation.¹⁹

Vague terms prevent accurate discourse on the needs of children who cannot live with their parents. The first issue is that terms have different meanings for different audiences. For example, “foster care” can be both a legal designation and a physical placement for children. “Foster care system” is also used interchangeably with “child welfare system,” even though the legal meaning of foster care describes only a portion of the CWS.

Similar arguments can be made to stop using terms like “formal” kinship care, which means kinship foster care in some states and kinship arrangements with legal capacity in others, and “informal” kinship care, which in some places encompasses both diverted and private care, while in other locations means arrangements with no legal capacity.

Contributing to the confusion regarding the hidden needs of children in nonparental care is that the term “foster care” legally describes only a fraction of children in nonparental care households. “Foster care” also masks overlapping subpopulations of nonparental care. Children can live in a foster care placement with kin or in foster care with strangers. Furthermore, in many jurisdictions, the kinship caregiver of a child in foster care may be unlicensed or licensed as a foster parent. Nonparental care households also include children living with kin outside the CWS. This arrangement outside the CWS can be due to a child welfare diversion or be a completely private arrangement.

Given these more nuanced household arrangements for children who cannot live with their parents, terms like “foster care,” “kinship care,” “formal kinship care,” and “informal kinship care” are insufficient to explain the unique constellation of resources, financial help, reunification support, and child welfare services available to each type of nonparental care family.

The adoption of universal nonparental family types is the first step toward building a shared vocabulary and subsequent vital understanding of the needs of children in nonparental care. Table 1 proposes six main nonparental household categories and lists the variety of descriptors used in the literature and practice to describe each type. Due to the variety of definitions in each jurisdiction, it may not be comprehensive, but every jurisdiction should be able to map subgroups based on how a nonparental care family fits the criteria.

Table 1. Subgroups for Children in Nonparental Care Living in Family-Like Settings (Households)

Nonparental Family Type	Child In Kinship Care?	CWS Physically Separated Child from Parent	CWS Legally Separated Child from Parent	CWS Provides Oversight of Placement	CWS Provides Reunification Services for Birth Parents (Permanency)	CWS Provides Training/ Financial Support for Caregiver	Subgroup Names	Broader Subgroup Names	Broadest Categories
1	Yes	No	No	No	No	No	Private Kinship Care	Informal Kinship Care Non-public Kinship Care	
2	Yes	Yes	No	No	No	No	Voluntary Kinship Care Diverted Kinship Care Hidden Foster Care		
3	Yes	Yes	No	Yes	Maybe	No	Safety Plan- Out of Home Prevention Plan VPA	Undefined	
4	Yes	Yes	Yes	Yes	Yes	No	Unpaid Kinship Foster Care Unlicensed Kinship Foster Care Approved Kinship Care	Formal Kinship Care Public Kinship Care State Supervised Kinship Care	Foster Care Public Care State Supervised Care
5	Yes	Yes	Yes	Yes	Yes	Yes	Paid Kinship Foster Care Approved Kinship Foster Care Licensed Kinship Foster Care		
6	No	Yes	Yes	Yes	Yes	Yes	Traditional Foster Care Stranger Care		

Exploring Pathways to Nonparental Family Types

Inadequate terminology and a lack of data tracking are not the only reasons for the limited research on nonparental care subgroups. Another contributing factor is an unwillingness to address head-on the inconvenient issues resulting from the intersection of child welfare and kinship care. The current underdeveloped understanding of kinship family formation and the resulting outcomes for children are problematic for at least three reasons.

The current discourse and debates surrounding the effectiveness of kinship care often do not consider that outcomes for the kinship triad differ based on nonparental family types, depending on the variable. This lack of shared understanding enables evasive child welfare practices and misguided policy around the use of kin, unfortunately applying broader labels to families who are distinctly different. One such example happens when child welfare policy continues to consider kin families who have no interaction with the CWS and those who exist only because of the CWS's interaction as the same subgroup, simply "informal" kinship care. This ignores the role the CWS plays in the creation of nonparental family type 2.

Second, data collection, including basic count data on each subgroup, is inadequate at best, nonexistent at worst, and different from jurisdiction to jurisdiction. Current data combine many nonparental types, resulting in unclear data on the different populations identified as nonparental family types, and this handicaps research by muddying the waters on outcomes by nonparental family type. The CWS takes an active role in determining access to foster care and plays a critical role in forming all but one nonparental family type, nonparental family type 1, but is not accounting for this role in its required data collection and reporting.

Finally, it is no surprise that research has thus far been insufficient to compare child well-being outcomes across nonparental family types thoroughly. Consider research that compares foster care to kinship care without acknowledging the overlap of kinship foster care. Outcomes and findings may be muddled by mixing kinship caregivers inside the foster care system with kinship caregivers outside the system or by not differentiating between licensed and unlicensed kinship care.

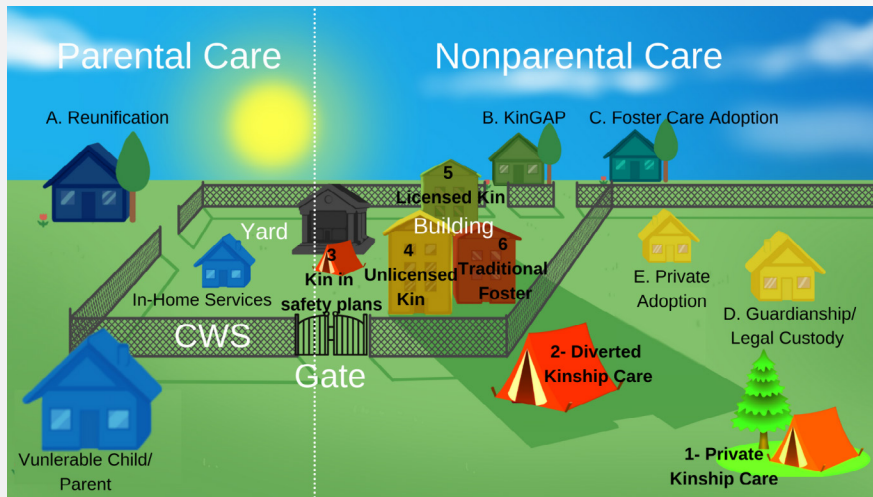
The cumulative effect of these inadequate definitions, murky child welfare practices, and incomplete data sets is a CWS that can be seen as shirking its responsibility to the very population it is charged to protect. Currently, it is scientifically difficult to point to child welfare practices or nonparental family conditions that could reduce the risk of maltreatment and increase protective factors for children in nonparental care. The incomplete picture could lead to inaccurately premised policy proposals and their resultant unintended consequences for subpopulations of children in nonparental care.

Mapping Nonparental Care Pathways

To correct these concerns, we must develop a shared understanding of all pathways to nonparental family formation created by CWS interaction. Figure 1 is a preliminary attempt to create a framework for studying nonparental family types, family type formation, and resulting permanency options.

The figure depicts a large field. In the middle of the field is a large yard wholly enclosed by a fence. In the yard are some tall buildings, a courthouse, and a tent. The buildings in the yard cast a long shadow into the field outside the fence. There is a closed and locked gate in the middle of the fence.

Figure 1. Nonparental Family Types in Relation to the Child Welfare System



The fence and everything inside represent the CWS as a whole. The court building inside the fence represents the legal oversight of the process from removal to foster care determination to reunification or alternative permanency. The gate of the CWS is where the decisions are made to bring children and parents into the system or prevent them from entering. The three tall buildings represent different types of foster care. On the left side of the field, children live physically with their parents in one of the blue houses. The numbered structures on the right side of the field represent the previously defined nonparental care subgroups. Nonparental family type 1, private kinship care, never interacts with the CWS. Figure 1 will be used to show how the remaining five nonparental types (2–6) are formed as a result of child welfare interaction.

What Happens at the Gate?

A child and parent bump up against the fence of the CWS, usually through a child protective services (CPS) investigation. What happens at the gate is an interesting mix of federal and state law, local child welfare policy, and the individual practices of street-level caseworkers. CPS workers make critical decisions regarding whether the child and parent should enter the fenced yard or remain outside in the field at the gate. It is at the gate that one of two main scenarios plays out.

In the first scenario, the CPS investigator determines if the child can remain safely at home with the parent. If so, the child and parent return to the parental care house in the bottom-left corner of Figure 1.

In gate scenario two, the risk to the child's safety meets the threshold to bring the child and parent into the system, and the child and parent enter the gate into the CWS. Children and parents can either go to the yard, representing safety/prevention plans, or into the building, representing foster care.

What Happens in the Yard?

In the yard, the child welfare agency determines that a safety plan is a suitable intervention. Legal custody remains with the parent. The worker and parent develop a temporary agreement outlining safety conditions that need to be addressed to avoid legally transferring custody to the child welfare agency. In some jurisdictions, safety plans are used only when children remain in the home with the parent and services are provided in the home. This scenario is depicted by the blue house in the yard of Figure 1.

In other jurisdictions, safety plans include the *physical* separation of the child and the parent. Many jurisdictions use the term "voluntary placement agreement" (VPA).²⁰ Out-of-home safety plans or VPAs allow the CWS to manage the safety threat and also potentially avoid court intervention.²¹ The child goes to live with a relative, or in cases where the parent lives with the relative, the parent leaves the household. In jurisdictions without the use of VPAs, the physical separation of a child and parent by using a safety plan is a practice that is not explicitly spelled out in the safety planning policies.²² The child and parent are provided services, but the child temporarily lives apart from the parent in kinship care. That arrangement, where children live with kin in an out-of-home safety or prevention plan, is designated by the tent in the yard and is designated as nonparental family type 3.

If the timeline of the safety plan or prevention plan expires before the safety concerns are ameliorated so the child and parent can exit the system and return home, then legal adjudication into a foster care case begins and is formalized through a court procedure. Only at this point does the child enter the "foster care system."

What Happens in the Building?

Children can enter foster care, designated by the buildings, either at the gate or in the yard as previously described. Foster care is the *legal* separation of the child from the parent. The child remains in foster care while the legal process of parental reunification or alternative permanency plays out. When the child enters foster care, the federal directive is for the child welfare agency to contact all adult relatives of the child within the first 30 days to let them know of their options to care for the child,²³ as well as to ensure the child lives in the most family-like, least restrictive setting. Priority is given to kinship placements.²⁴

Nonparental families in the foster care system include nonparental family type 4 (unlicensed kinship foster caregiver), nonparental family type 5 (licensed kinship foster caregiver), or nonparental family type 6 (a traditional foster parent). During the time the child is in foster care, the parent is also provided services, and the CWS supports the child. The three buildings in Figure 1 represent the three nonparental placement types for children in the foster care system. Not all jurisdictions have both unlicensed and licensed kinship foster care options.

Many, but not all, states allow kinship families to take placement of a child in foster care without going through the process to become a licensed foster parent. Often called unlicensed, unpaid, or unapproved kinship foster care, this category makes up nonparental family type 4. This type of care looks equivalent in every way to traditional foster care, but unlicensed kinship foster parents receive no financial support, receive no training, and don't undergo a complete home study process. This has real negative ramifications for the child.

Jurisdictions can offer a path for a kinship caregiver to become a fully licensed foster parent for their relative, which is nonparental family type 5. Once the caregiver undergoes the same process that it takes to become a traditional foster parent, that caregiver should have access to equivalent financial reimbursement and the training and other supports that come with being a traditional foster parent.

Traditional foster parents — nonparental family type 6 — are non-kin families who open their family home to children in foster care. They are vetted and trained, and receive reimbursement for their work.

There are three potential concerns about the use of kin in the foster care system. First, in states that allow unlicensed kinship foster care, there may be a temptation to rely on the unpaid labor of kinship families to save money. There should always be a clear and supported path to licensure, so children in kinship foster families receive equitable resources that are available to traditional foster families.

Second, in jurisdictions that do not allow unlicensed kinship foster care, there is a risk that once a child enters foster care, the requirements for kin to receive placement are so high that they cannot be met, and the children end up in traditional foster care. States with no option of unlicensed kinship care are also more likely to have formalized diversion practices to keep children out of foster care altogether.²⁵

The final concern is tracking and data. States must report the case-level information on children in foster care to the Adoption and Foster Care Analysis Reporting System (AFCARS). One of the data points is "most recent placement type."²⁶ The options for children in households are "pre-adoptive home," "foster family home — relative," and "foster family home — nonrelative." States are not required to report what number of the larger kinship foster care subgroup are licensed and how many are unlicensed. There are also concerns that fictive kin placements, which are placements with individuals with whom the child has a kinship relationship based on friendship or social arrangement as opposed to sanguinity, adoption or marriage, are being coded as nonfamily homes.²⁷ Research on the outcomes for children in kinship foster care will be insufficient if these distinct subgroups are not made explicit, as the resources available to each type are different, including options for permanency.

CWS Diversion at the Gate, Yard, and Buildings

One of the largest unknowns is how many children and families make up the “hidden foster care” system identified as nonparental family type 2 — in the tent in the shadow outside the CWS fence of Figure 1. This nonparental family subgroup is created by the CWS through a process commonly known as “diversion.” Diversion is an alternate ending for families who interact with the CWS that ultimately results in the nonparental family residing in the shadow of the CWS.²⁸

Diversion can occur at any critical window at the gate, yard, or building. While the exact number of children diverted from the CWS into kinship care is unknown due to a lack of data collection,²⁹ at one point in time it was estimated to be 400,000,³⁰ and other studies found half of children involved in a CWS investigation were diverted to live with kin.³¹

At the gate, child welfare worker may, through encouragement or coercion, ask a kinship caregiver to take the child or ask a parent to “voluntarily” place their child with kin in order to prevent entry into the CWS at all. The child ends up living with kin outside the system with no record of having encountered the system at all. The child welfare worker prevents entry to the CWS while simultaneously *physically* separating the child from the parent into a kinship care home. Diversion at the gate is done without parental representation or judicial order and often with a promise to “close” the investigation after the parental separation is completed or promised.³²

In the yard, diversion provides an alternative to successful parental completion of safety or prevention plans. At the end of both in-home and out-of-home safety or prevention plans, the investigation should either be closed out or the process of legal removal begun. Yard diversions occur by shifting *legal capacity* from the parent to the kinship caregiver at the end of unsuccessful safety plans to avoid foster care — the legal transfer of custody from the parent to the CWS.

Finally, diversion can happen once the child enters the building. A common scenario is an unlicensed kinship caregiver showing openness to having legal custody transferred to them to close the foster care case. Depending on the jurisdiction, this could be in the form of legal guardianship or permanent legal custody. Diversion in the building means the foster care case can be closed without pursuing reasonable reunification efforts or termination of parental rights. Inside-the-building diversion is distinguished by foster care cases that are closed quickly with a shift of *legal custody* from the child welfare agency to the kinship family. Diversion from the building shuts off access to subsidized forms of legal permanency for the caregiver and reunification services for the parent.

While most jurisdictions do not have explicit policies regarding these three diversion practices, the negative impacts of the diversions are frequently reported by kinship families.³³ Once diverted, these CPS-formed nonparental family types live in the shadow of the foster care system. This shadow represents the similar needs of the kinship triad with no access to the resources inside the fence.

There are at least four main reasons for diversion. In some cases, diversion into kinship care is because the worker does not feel comfortable with the child remaining with the parent but does not have enough evidence to bring the case in front of a judge. This frequently happens when the threshold for removal is unclear or unmet, but the child welfare worker or kinship caregiver still has concerns for the child. In other cases, the worker is so overburdened that keeping the child from entering or remaining in the system is a way to reduce their workload. In a third scenario, caseworkers may be well intentioned with diversion and think that by diverting into kinship care, they meet the requirements of “relative placement” mandated by their jurisdiction.³⁴ And finally, it is simply cheaper for the CWS to have fewer children in the foster care buildings, and pressure to cut costs may trickle down to practice on the front lines.

The emotional conditions under which the diversion occurs can usually be grouped into two broad categories. In the first, the kinship family is a willing partner in the diversion, wanting to do whatever it takes to avoid the CWS intervention in their lives, the child's life, and the parent's life. In the second, the worker coerces the kinship family into taking the child, “or else...” The kinship caregiver may feel there is no alternative due to the power differential between them, combined with ignorance of the options for the parent, the child, and themselves. In almost all diversions, whether the kin caregiver is willing or coerced, there is an element of fear of the unknown — of “foster care” — and ignorance of the legal processes inside the fence.

The end result is that diversion practices create a large population of children separated from their parents in the shadow of the CWS, also known as hidden foster care. As stated, one of the most frustrating aspects of diversion practices is that such diversion into kinship care is not tracked by the CWS doing the diverting. Because it is not tracked, the outcomes for the children in diverted nonparental care are challenging to quantify. It is unknown how many children are going into diverted kinship care, what happens to the children, what happens to the birth parents, and what happens to kinship caregivers.

There are also legal issues related to diversion practices. Legal arguments brought forth by parents' attorneys and kinship advocates challenging the practice have been made regarding violations of Title IV-E of the Social Security Act, equal protection under the 14th Amendment, and due process under the Fifth Amendment.³⁵ Specific legal concerns include issues surrounding the physical separation of children from parents without representation when separation is not warranted. When separation is unwarranted, diversion deprives parents of a clear path to reunification with their children.

Advocates for kinship families also express concerns related to separations that may be warranted but were never adjudicated, thus depriving families of the services they would otherwise be entitled to receive. When legal separation is warranted but not adjudicated, diversion deprives caregivers of their rights to become foster parents and access permanency outcomes tied to the child's foster care status.

The Path to Home or Permanency

To some degree, all six subcategories of nonparental care represent a temporary form of care. Family permanency options for children in nonparental care inside the CWS include reunification, adoption from foster care, or guardianship options.³⁶ Nonparental family types 3–6 have clear timelines and a clear path to parental reunification, depicted as an exit from the fence to the house with flowers in the top left of the image. Because reunification is almost always the first goal when the CWS is involved, there are many resources put toward ensuring children and parents inside the system can exit together.

When reunification is not possible in the CWS, alternate permanency for the child is required. The kinship family type restricts permanency options. For example, only nonparental family type 5 — licensed kinship families — have the option of KinGAP, a form of federally subsidized guardianship.^{37,38} Table 2 outlines permanency options that are generally available to each nonparental family subgroup.

Table 2. Permanency Options based on Nonparental Family Type

Nonparental Family Type	Subgroup Names	A. CWS Assisted Reunification	B. KinGAP	C. Adoption from Foster Care	D. Legal Guardianship / Permanent Custody	E. Private Adoption
1	Private Kinship Care				x	x
2	Voluntary Kinship Care Diverted Kinship Care Hidden Foster Care				x	x
3	Safety Plan- Out of Home Prevention Plan VPA	x				
4	Unpaid Kinship Foster Care Unlicensed Kinship Foster Care Approved Kinship Care	x		x	x	
5	Paid Kinship Foster Care Approved Kinship Foster Care Licensed Kinship Foster Care	x	x	x	x	
6	Traditional Foster Care Stranger Care	x		x		

Issues related to reunification outside the system include timeliness, appropriateness, and services to birth parents. Nonparental family types 1 and 2, operating outside the CWS, do not have well-defined pathways home for the child. That leaves the kinship triad in types 1 and 2 to fend for themselves regarding assessing safety, planning visitation, reunification, and a host of other concerns. Given the myriad of family systems and potential generational trauma present in some kinship families, this do-it-yourself pathway is fraught with pain and peril.

In addition, kin families outside the system have no access to federally subsidized permanency options such as adoption from foster care or subsidized guardianship (KinGAP).³⁹ The pathway to those outcomes runs right through the foster care buildings (Table 2). Instead, private and diverted families must sort through legal options outside the system, including temporary guardianship or power of attorney, legal guardianship or other custody proceedings, or private adoptions. For kinship caregivers outside the system, the burden of determining the best legal option, including filing and fees, falls directly on them.

FFPSA and Kinship Care as Prevention

The 2018 Families First Prevention Services Act (FFPSA) provides more services to children and parents in the yard. The intent of the FFPSA is to allow states to draw down federal dollars previously tied to foster care status in order to provide prevention services for parents and children without the requirement of *legal* separation of children into the foster care system.

Kinship support advocates face a precarious transition in child welfare with the implementation of the FFPSA, which gives jurisdictions with an approved Title IV-E plan the option to use IV-E funds for prevention services that would allow “candidates for foster care” to stay with their parents or *relatives*.

One type of service available for IV-E funding as part of a “prevention” plan is a *kinship navigator program*.⁴⁰ While other IV-E-approved prevention services in general are interventions for parents and children that allow the child to remain in the home, the inclusion of kinship navigator programs as IV-E prevention services provides evidence that federal child welfare leaders may consider *physical* separation of the parent and child into kinship care as a prevention from foster care. This raises the question, “What does kinship care prevent?”

To state the obvious, by its definition, kinship care is not possible without parental separation and therefore can never be considered prevention of parental separation. Therefore, kinship care used as part of a “prevention plan” is not preventing potential trauma resulting from the physical separation of children from their parents.

It is also not adequate to say kinship care “prevents” foster care, since kinship care happens both inside and outside the system. What is accurate is that all five types of kinship nonparental care prevent nonparental family type 6 — placement in the foster care system with traditional foster parents.

The FFPSA extends the duration and number of services that can be provided in the yard of the CWS. Similar to the discussion of safety plans, parents will be provided a prevention plan. The FFPSA allows parents and children to be served in the yard for an initial period of 12 months with the option to extend for another 12 months.⁴¹ During that time, kinship families who are “in the tent” for up to 24 months will not have access to financial support or training that is provided “in the building.” Therefore, if a state plans to use kinship placements as part of the prevention plan services, explicit financial resources need to be made available to the kinship family that do not harm efforts for reunification.

However, based on the limited services available for the kinship triad under FFPSA-approved services, the CWS will be limited in its ability to provide appropriate financial support for the newly created nonparental care family. Currently, the only financial support relatives may have access to is financial support from a welfare program called child-only TANF (Temporary Assistance to Needy Families), but receiving this cash assistance is dependent on the state pursuing the parents for child support. It is also only available in most states to relatives of a specific degree who are able to prove relationship to the child. This excludes families such as fictive kin, paternal relatives where the father is not on the birth certificate, and relatives who take in half-siblings.⁴² All of these restrictions will be counterproductive for both parents and kinship caregivers.

Under the FFPSA, the reliance on kin as “prevention” from the foster care system shifts the burden of nonparental care from a group of kinship caregivers who were either financially supported or had access to financial support through foster care reimbursement to a group of caregivers without access to support. It will come as no surprise when out-of-home prevention plans relying on unsupported kin backfire as caregivers disrupt the placements due to lack of resources. Without careful implementation plans protecting kin who are used as prevention resources, the FFPSA opens the door for jurisdictions to further shift the burden to unsupported kinship placements that are potentially disruptive for the child.

The FFPSA is silent on CWS diversion at the gate. Post-FFPSA implementation, this practice will be expected to continue as agents of the CWS continue to conflate child safety with the physical separation of children from parents into diverted kinship care. While gate-diverted kinship care helps the system meet the goals of preventing entry into foster care, *it does not prevent child separation from the parent*. The physical separation of children simply happens outside the foster care system, and jurisdictions receive praise for this practice.⁴³

Ultimately, the real measure of success post-FFPSA implementation will be not just a reduction in the number of children in foster care but a reduction in the overall number of children in nonparental care. This measure of success is possible only with proper definitions, data collection, and research design. In addition to reducing foster care, future policy should endeavor to explicitly ensure this reduction is not at the expense of other types of nonparental care.

Nonparental Family Formation and Equity

Access to services for the kinship family triad has long been identified in the literature as a fundamental equity issue for children in nonparental care. A great deal of research focuses on the lack of resources for informal and unlicensed kinship families compared to traditional foster families. Given that kinship caregivers have been shown to be older, more likely to be disabled and living on a fixed income, and more likely to be single caregivers than traditional foster parents, this has been an area of concern for some researchers.⁴⁴

Arguably the needs of children in nonparental care may be similar regardless of the type of nonparental care family in which they reside; however, financial resources for kinship families are currently more abundant in the foster care system. Resource access is primarily governed by foster care status. Resources for the kinship triad look different on the outside of the fence versus on the inside, with families on the outside struggling to access resources or not having access at all. Most obviously, kinship caregivers who are outside are not even eligible to access resources that exist for kinship families within the foster care building, including foster care reimbursement and training.

Policies intended to reduce foster care through the use of kinship diversion as opposed to parental separation prevention actually prevent children from accessing needed services and may be counterproductive to ensuring equitable outcomes for children who can't live with their parents.

With regard to equity, one data point should be whether some populations of children are disproportionately *physically* separated from their parents into nonparental care. It is imperative to understand the number of children who are physically separated from their parents, whether it be into foster care or diverted kinship care, and look at equitable access to resources for children in nonparental care. Data should be tracked and made available on the number of children who interact with the CWS who are able to stay in their home versus those who are physically separated from their home.

Once children are in foster care, appropriate equity questions require looking at disproportionality in both separation from family and in access to services. First, are children more likely to be separated from kin and placed with *strangers* in traditional foster care? Second, if the child is in kinship foster care, which children are more likely to be in *unlicensed/unpaid* kinship foster care? If children are brought into kinship foster care and that kin family has the training, financial support, and access to mental health and medical care for the child, that situation is potentially better than that of a child who is in unlicensed kinship care with none of the support.

Equity concerns may not be fully addressed until jurisdictions are required to report on how many children are in these paid versus unpaid kinship foster placements. Simply reporting on the overall number of children in kinship foster care versus traditional foster care versus other foster care settings is not sufficient to ensure equity for children in the foster care building.

The path forward to fixing the inequity of resources for children in some forms of nonparental care lies with identifying the terms and concepts that hold different meanings across jurisdictions as well as laying bare the process by which nonparental care families are formed through interaction with the CWS. Only by naming and understanding the complex, contentious, and emerging issues for children and families in relative and fictive kin homes will progress be made in addressing inadequate services for kin families that may disproportionately affect children.

Recommended Actions

To move toward research that will inform kinship practices and evidence-based interventions for nonparental care, the following five actions are recommended.

First, adopt universal nonparental family type descriptions and work from the same map. This clarity is required to improve data collection and rigorous research designs. As with most things in child welfare, there are no easy solutions to complex work. However, until there is a map and a common language, advocates are essentially speaking gibberish to each other some of the time. It is impossible to have a conversation about policy unless participants are communicating about the same population, the same process, the same pathway, and the same outcomes. A framework like the image of the fence in the field may improve these conversations.

Second, child welfare systems must collect and report data based on the universal nonparental family types touching the CWS including how many children live in paid versus unpaid kinship placements, and the number of and demographic information on children who are diverted out of the CWS into nonparental family type 2.⁴⁵ Accurate subpopulation data are necessary for rigorous research on nonparental family subgroups.

Third, states should specifically be required to outline how kinship care will be used “in the yard” as part of a state FFPSA prevention plan. Any *physical* separation of child from parent should be made explicit in policy and provide for appropriate representation for the parent and full disclosure of options given to kin used as prevention resources. This is in line with one of the recommendations put forth by the National Workgroup on Hidden Foster Care, which reads as follows: “Amend the Family First Prevention Services Act to clarify that children removed from their homes and placed with relatives are not ‘candidates for foster care,’ but are in foster care, and that any kin providing care in these circumstances shall be afforded the rights and benefits or similarly situated kinship foster parents in their state or locality.”⁴⁶

Fourth, push for the further delinking of resources for the kinship triad from foster care status. While the FFPSA will delink resources from the building and direct them to the yard, it does not go far enough in supporting kinship caregivers who are providing children and families resources that prevent children from entering foster care. Children in nonparental family type 2 — diverted kin — and nonparental family type 3 — safety/prevention plan kin — will not have access to the supports available to kin in the foster care building, such as training and foster care reimbursement. Fixes should correct current restrictions to the child-only TANF grants such as the child-support enforcement requirement and exclusion of certain types of kin caregivers. Regardless of foster care status, children in nonparental care have similar needs.⁴⁷ Equity for children in nonparental care will increase by ensuring equitable access to intervention by delinking resources from the CWS and into the community.

Fifth, recognize the need for independent kinship navigator programs. Kinship caregivers are often at a disadvantage at each critical window of decision making. They arrive at caregiving via crisis and are expected to make quick decisions without having all the information to make the best decision for their family. A quality navigator program will be well versed in understanding the nonparental family types in the area and the corresponding legal options and resource options for the kinship triad. Kinship navigator programs should offer accurate, timely information on all options for each nonparental family type and assist families in understanding critical decisions and timelines for all nonparental family type formations.

Until more rigorous research is available on outcomes for all nonparental family type subgroups, navigator programs should guard against actively facilitating diversion practices for the child welfare agency or serving only one subset of kinship families instead of all kinship nonparental family types. Until resources for the kinship triad are equitable regardless of foster care or child welfare status, then navigator programs should commit to providing information for families to help them make informed, supported decisions for their children without pressure or influence from the CWS.

Conclusion

To shift thinking in the child welfare field from seeing kinship care as “prevention from foster care” to seeing it as “an intervention for children who cannot live with their parents” requires challenging the field to acknowledge the pathways to nonparental family formation for each subgroup and assigning appropriate accountability for family stability based on those pathways. Moving from foster care prevention and toward nonparental care intervention will help advocates, leaders, and policymakers direct appropriate resources to kin families who are helping children who have experienced parental separation and adverse experiences. For kinship care to be a consistently superior alternative to traditional foster care, all kin families should have access to some level of financial support, training, and services that are based on the child's needs, not the child's foster care status.

The development of a standardized framework to discuss kinship care is long overdue in the child welfare field in the context of child welfare policy and practice. The delay may be deliberate, in part, because redefinition, updated data collection practices, and improved research design require acknowledging the active role the CWS plays in nonparental family formation. The acknowledgment will have serious implications for the CWS's accountability to the families it encounters. Child welfare systems that have relied on diversion practices celebrate reducing their foster care numbers without acknowledging that the number of parental separations may not have changed. The system has simply taken an active role in shifting the burden of caring for a child in nonparental care from caregivers who have access to training and support to caregivers with limited support and no oversight.

The field must boldly reframe what success looks like by accounting for the CWS's role in *physical*, not just *legal*, separation of children from parents. Instead of aiming to reduce the number of children in foster care, the challenge to us all is to increase the number of children able to live safely with their parents.

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Establish a New Program within HHS to Combat Child, Youth, and Family Homelessness

Cara Bradshaw, Family Promise

Cara Bradshaw is the Chief Impact Officer at Family Promise

Savannah Foxx, an EMT in Savannah, GA, who spent the last two years helping COVID-19 patients, experienced homelessness with her five children after leaving an abusive marriage.

“Being homeless with five kids was definitely something I never imagined,” Foxx said in an interview on Sunday TODAY with Willie Geist in March 2021.¹ At the time of the story, the Child Tax Credit, a part of the 2021 COVID-19 Relief Package, offered Foxx’s family just over \$15,000 from mid-2021 to mid-2022.

The legislation has been touted for its potential to cut child poverty in half, according to a study by Columbia University.² It is estimated to help 9 of every 10 kids in the United States. “That can help with groceries. That can be added help for bills. That can be money that I put aside for their future,” Foxx said.

Foxx and her children received shelter and support from Family Promise of the Coastal Empire (Savannah, GA) while experiencing homelessness. They are now in a home of their own, with a savings buffer, and Foxx works three jobs. It’s a constant challenge for her to juggle employment, childcare, and her children’s education.

Unfortunately, Savannah’s story is not uncommon. Families with children make up 30% of the nation’s homeless population.³ And wages simply have not kept up with the cost of housing: in no state, metropolitan area, or county in the U.S. can a worker earning the federal or prevailing state or local minimum wage afford a modest two-bedroom rental home at fair market rent.⁴

The Issue & the Family Promise Solution

The Department of Education estimates that 1 in 19 children will experience homelessness before they enter the first grade. That’s equivalent to one child in every kindergarten classroom. Family homelessness is endemic, yet often hidden.

Families who experience housing instability usually experience multiple challenges that lead to their homelessness, such as separation or divorce, unaffordable and unavailable childcare, transportation problems, or an accident or disability. And many families who experience housing instability have no financial or family safety net.

There are systemic inequalities that compound challenges for families. More than two-thirds of the families served by the 200 Family Promise Affiliates in 43 states are women-led households. And there is an unfortunate and obvious connection between overt disenfranchisement, structural racism and injustice and the fact that more than 50% of those experiencing homelessness are Black while making up only 13% of the total U.S. population.⁵

For more than 30 years, Family Promise has offered a community of support and an integrated approach that reaches beyond immediate needs. We initiate coordinated local efforts that bring communities together to help families experiencing homelessness regain their housing, their independence, and their dignity. We do this through prevention and shelter diversion, emergency shelter, and long-term stabilization support.⁶

Keeping families out of shelter is good public policy and good fiscal policy. Family Promise prevents family homelessness through landlord mediation, making payments for rent in arrears, offering security deposits for new housing, through budgeting programming, workforce development

initiatives, and more. Diversion programming helps families avoid shelter by finding alternate housing solutions, including with family members, or in a temporary living situation until permanent housing can be secured.

Homelessness prevention costs a fraction of the funds required to rehouse a family once they lose their home. The costs to rehouse a family are upward of \$15,000, including shelter and case management costs, and rental deposits, which are often 3x the cost of the monthly rent. At the same time it costs, on average, \$1,100 to prevent a family's homelessness and \$290 for a child.⁷

The cost — both human and financial — of allowing homelessness to exist is staggering. High-school dropouts contribute less tax revenue and rely more heavily on public services. Failure to finish high school results in an estimated net negative of \$127,000 per child.⁸

Because of the shame and stigma associated with homelessness, family homelessness is an unseen national crisis. Low-income families often do not seek help or know where to turn until they are facing eviction. Catching families before they reach the point of losing housing, or innovating solutions for housing that avoid shelter, saves the family and community valuable resources and avoids the trauma of losing their home.

Family Promise Case Studies

Through interviews with Executive Directors of Family Promise Affiliates in the South and families they have served through shelter and other programs, we distilled some of the major themes low-income families with children face, which lead to and are a result of experiencing homelessness:

- Childcare is unaffordable and unavailable, particularly for second- and third-shift workers
- Children's educational outcomes and mental health decline when experiencing housing instability
- Because families often have little access to affordable health care, they often accrue health-care-related debt for preventable conditions
- Affordable housing options are few, particularly for larger, blended, or multigenerational families
- Transportation challenges cut working parents off from access to jobs and cut children off from medical care and pre-K

Affiliate Case Study 1: Family Promise of Davie County (Mocksville, North Carolina)

Childcare is simply unaffordable or unavailable for low-income families since the onset of the COVID-19 pandemic has eliminated providers, and there are limited options for parents who work second- or third-shift jobs.

Even pre-pandemic, in 33 U.S. states, The Care Index showed the average cost of full-time, in-center care for one child under age four has eclipsed that of in-state public college tuition.⁹ Experts recently reported the cost of child care has doubled during the pandemic.¹⁰

"Childcare subsidies for low-income families are few, and even if a family is granted a subsidy, the parent(s) must prove their hours first," says Lisa Foster, Executive Director of Family Promise of Davie County, NC. "It's a catch-22, because if childcare is what is keeping you from holding down your job, what do you do?"

Foster added that non-faith-based facilities in her community are full. "Even if you had the money, there isn't space available. And there is no second- or third-shift childcare. Most of the families we work with are second- or third-shift workers."

Davie County is a mostly rural county, and as such, access to pre-K or Head Start is a challenge. "Many families don't have their own transportation. In rural areas, we don't have public buses. Families would be eligible for services, but don't have a way to get there. Kids are missing out on these opportunities. As we know, it's so important to get kids started early with learning to have those building blocks in place," Foster said.

Additionally, families without transportation have difficulty accessing grocery stores, doctors' offices, and other basic resources. "They literally get stuck, and cut off, and the children don't get the care they need," Foster explained.

She also spoke to what happens to children when they experience housing instability and how much their educational outcomes improve when they are stabilized. "We had a grandmother and grandson in our shelter program pre-COVID. They had been staying in an unsafe hotel. The grandson was in middle school and is autistic. We got him enrolled in [the] county's alternative school and talked to the staff and teachers there about his behavioral issues," Foster said.

Once in a safe shelter setting, the young man started thriving at school. He and his grandmother moved into permanent housing on the last day of school. When he enrolled in school the next year, he was able to return to a standard classroom setting. "He's doing really well. He made honor roll and is involved in extracurricular activities. He's been completely turned around and reintegrated into the educational system," she said.

During the COVID-19 shutdown, Foster worked with a mother and teenage son who were receiving case management and financial assistance while living out of a motel room. "He was doing virtual learning at the motel, and because of his mother's multiple jobs, he was unsupervised 80% of the time. It was not safe, and he got involved with people around the motel who were dangerous. Had he been in his own home or other safe setting, this would not have happened. Juvenile justice got involved and it was taken out of our hands," she said.

Federal policies are so often focused on chronic homelessness and do not focus on the needs of families with children, Foster argues, explaining, "90% of families we serve would not be considered homeless by HUD's narrow definition. Most children experiencing homelessness in our community would not qualify for any services. We need the Homeless Children and Youth Act¹ to expand the definition of homelessness." Currently, HUD does not consider families self-paying in motels or doubled up with family and friends as homeless.

Foster also offered policy ideas that she says would be “game-changers” in her community and that could prevent family homelessness altogether:

- Incentives for corporations to offer childcare onsite or childcare subsidies for their workers, especially those who have second- and third-shift work
- Trial periods for child-care subsidies/vouchers instead of requirements to prove hours and show paystubs before receiving childcare, which inhibits parents starting new jobs
- Better and more structured cross-sector partnerships to create affordable housing
- Public awareness efforts and public education around affordable housing to break down the stereotypes that lead to a “Not In My Backyard” mentality
- Toolkits that can help communities tailor federal policy changes related to housing, health care, education, and childcare to their own unique populations

We need to think bigger and outside of the box, Foster argues: “Even in the South, there are so many churches that have closed, who are closing, or who don’t use their buildings. There is land sitting vacant, unutilized. Seeing all this space and the huge need is frustrating. It’s a missed opportunity. Nonprofits can’t do all the service work. With federal incentives and creative cross-sector partnerships, we could prevent more families with children from experiencing the tragedy of losing their homes.”

Affiliate Case Study 2: Family Promise of Blount County (Maryville, Tennessee)

Caroline Lamar, Regional Director-Southeast and former Director of Family Promise of Blount County, Tennessee, echoed the challenge of unaffordable and unavailable childcare as a major impediment for families, along with a lack of affordable housing options for larger families and soaring medical debt.

“Childcare is the number one problem for families we serve. You can have the best job in Blount County, but you might not be able to find an option that works for your family right now. Availability is limited. It’s not just an affordability issue,” she said.

There are not enough workers at afterschool programs either, reports Lamar. She shared, “One mom we have in transitional housing just started working what she says is ‘the best job she’s ever had.’ But the childcare facility wants eight recent, consecutive pay stubs, and it’s a new job.”

Luckily, Family Promise was able to serve as the stopgap for this family. “We provided childcare in the interim until she could get her eight pay stubs,” Lamar stated, “But if you take Family Promise away, this mom would not have had childcare. This is a woman working a job she loves, with potential for growth, at more than minimum wage. Childcare is a women’s empowerment issue.”

Last August, Lamar worked with a mom whose baby was born in Family Promise shelter. “We drove mom and baby home from the hospital and our case manager was home with the three siblings. Where would the kids have gone if not for us? She had nowhere to leave them and no one to watch them. The state might have gotten involved if Family Promise wasn’t there,” said Lamar.

She noted that one mother's situation underscores the lack of a family safety net for so many: "This mom had no support system of any kind. If you have a sick child, what happens to the siblings when you need to care for the sick child? And how are you supposed to work? These kids are falling through the cracks of the family unit. There are so many out there. These are just the ones we know about."

Family Promise of Blount County also served a family with four children in 2020. One of the children needed heart surgery, but the family had nowhere to turn for help navigating the medical system. "Family Promise and the school system stepped in. Mom and dad would have slept in their car outside of the hospital otherwise. We ensured childcare and transportation for the siblings. We got them fed. We were able to connect with social services at the hospital to let them know about the situation and where they could stay. The family was so overwhelmed — they didn't know what was available to them," Lamar shared.

Today, she reports, the child is healthy and doing well in school, as are the three siblings. The family is permanently housed without medical bills that would have only compounded their challenges. "The biggest cause of collections for the families we serve is medical debt. Not credit card debt. Families live in a constant state of emergency. The checkups tend to slip, they need teeth pulled. It's not neglect. The parents have no time, or no reliable transportation to take their children to the doctors. This results in higher medical expenses down the road," said Lamar.

Housing instability also leads to poorer educational outcomes for children in Blount County, Lamar noted: "These kids have lower reading comprehension, lower test scores, and often haven't had a consistent education because they've moved a lot. How can you expect them to gain any ground when they're having to reinvent themselves in the classroom? And in a rural county, they often don't have connectivity at home, even if they have the hardware from school."

Recently, Lamar served a family with three children, not all the same sex, staying in a hotel. The mom and dad stayed in one bed and the two same-sex children in the other bed. "One child had to sleep on an inflatable pool float," she said. "So, the next morning you have to get up and go take your math test. How do you think that's going to go? Still, the adults in their life expect them to show up and perform to meet state standards. It's hard to do that when they're experiencing the kinds of things you do when you experience homelessness."

Lamar has also seen an increase in larger, blended families for whom there are limited housing options. She noted, "It's common for couples to merge their families and have multiple children from a previous marriage. It's already a challenging housing market, but if you have a family of six with children of different ages and sexes who need separate bedrooms, that space within their budget just does not exist."

Blount County has seen Amazon and other large employers move in over the last five years. "It's compounding the problem instead of alleviating it," Lamar said. "The company moves in and brand-new apartments spring up, but a one-bedroom starts at \$1,179 — that's unattainable for every single one of our families in shelter. And not one of the families we're seeing now can live in a one-bedroom."

All families currently served by Family Promise of Blount County are employed, Lamar reported, but they still cannot make ends meet: "The assumption is that they're lazy and that's why they're in the position that they're in. There is extreme bias against families experiencing homelessness."

Lamar shared thoughts on reforms that could help families and children in her community:

- Childcare relief and policies that allow parents starting new jobs to get childcare before providing pay stubs
- Universal parental leave
- Universal sick leave
- Connectivity and access to the Internet, particularly for children in rural areas
- Larger, affordable housing units for families who work for companies who move into the county

"So many families get stuck in generational poverty where you've never seen anything but survival mode. They get sick and have no sick leave. They have a baby and have no one to care for the baby but have to go back to work," Lamar said. "That's why I love Family Promise so much — we're breaking that cycle. Kids are seeing their parents find a support system in the community, work hard, budget, and succeed."

Affiliate Case Study 3: Family Promise of the Midlands (Columbia, South Carolina)

Jeff Armstrong, Executive Director of the Family Promise of the Midlands, looks to solutions in the educational system to help children growing up in poverty and experiencing housing instability.

"We depend so much on the school system to be everything for our children, especially low-income families. They are the therapist that the parent can't afford, the doctor that they don't have time to see, the parent who's not there because they're working all the time. The parent is forced to depend on the school being the answer," Armstrong said.

For low-income families, particularly families of color, there are barriers to engagement with the schools and their children's education, Armstrong said. As housing costs continue to rise, parents are finding less time to spend with their children because they are working more. He noted, "Maybe they didn't have the behavior model that they should be present, or they don't feel like they deserve to be sitting at the table, or they're working multiple jobs and simply physically cannot show up."

Children experiencing homelessness often don't have adults who are present who can demonstrate success, Armstrong argued. "There is so much guilt and shame around living in a shelter. We were working with a child, 12, who got off a bus and walked the opposite way of Family Promise because he didn't want anyone to know what was happening to his family."

These kids must work much harder in school than housed children, Armstrong said, and they often don't have people in their household who can support their educational progress: "That same child, when you ask them what they want to be when they grow up, they don't know because they don't have a model for thinking about their potential. When you can't dream big as a child, there are implications that will make or break you as you head into your teenage years."

Armstrong speaks from personal experience and offered an approach he uses with youth in his programs. "I'm in this field because I figured out a way to build a blueprint to avoid things I didn't want to succumb to or patterns I didn't want to follow," he said. "I want our children to realize they have an extra gear they can kick into. You can use that gear to figure out ways to get what you want and need that will help you create a long-term strategy, not just survive in the moment."

One teen Armstrong worked with recently, who he described as the “man of the house,” cared for his younger sister while his mom worked two jobs with long hours. “When they entered Family Promise housing, mom was able to get her teaching certificate to teach elementary school and have better hours for the family. We asked him what he wanted for his birthday and threw him a party. It took a huge weight off mom’s shoulders. He got a job and was made manager of his summer job at 17. I told him, ‘When you come through this, you can use what you’ve gone through to your advantage.’ The stability of their housing made it possible.”

Armstrong tries to ensure the voices of families in his program are at the table for decisions. “We need to spend more time in communities that are predominantly low-income and hear from them and build relationships and not just one-off events. We need to have parents be involved in what’s being built for their children,” he said. “There are people in the community that everyone trusts. They should be part of the decision-making process around policies that affect them.”

Efforts that would empower parents and children in Armstrong’s community include:

- Stipends for community leaders who can translate major federal policy reforms to the local level and empower their fellow citizens
- Resiliency teams in schools that bridge the gap for children who haven’t had the right foundation and can build relationships with parents to create better outcomes
- Youth Advisory Boards that bring young people to the decision-making table

“At Family Promise, we’re bringing two cultures together — one that knows nothing about poverty or homelessness and the other could tell you about it all day long,” Armstrong explained. “If you don’t come from poverty, you’re not going to truly understand what’s going on for their families, and their children, and what reforms would actually help them.”

Conclusion

Family homelessness is a complex issue requiring a holistic response and an integrated approach. Because it affects so many areas of a family’s life — health care, wellness, education, childcare, employment, transportation, systemic barriers and inequities — the solution must address so much more than shelter and housing.

Experiencing homelessness is a significant trauma to a family. Studies have shown that single mothers experiencing homelessness are a highly traumatized and underserved group; 93% of participants had a history of trauma, with 81% having experienced multiple traumatic events.¹² Understanding the impact trauma has had on the lives of those receiving services is a critically important starting point to a comprehensive approach. We must be able to identify the signs and triggers of trauma and avoid retraumatizing those seeking services. We must understand what happened to them and learn effective strategies to help clients heal.

With this understanding, we can begin to address the particular issues facing each family and empower them to achieve their goals of financial and housing stability. From childcare to assistance with transportation, rent, health-related expenses, and more, we can support families and reduce the risk of a fall or reentry into homelessness.

And we must also address the systemic failures that have made it more difficult for families to succeed. Families face extraordinary challenges:

- A lack of affordable housing options, especially for blended and multigenerational families
- The astronomical cost of health care, which leads to debt for many
- The lack of available or consistent parental or sick leave
- Low-wage employment that causes many adults to work multiple jobs
- The lack of affordable, reliable transportation so people can get to and from work, school, interviews, childcare
- Educational disadvantages for students experiencing poverty and housing instability
- Structural inequities that have allowed race to define who has access to housing

We recommend that the U.S. Department of Health and Human Services (HHS) create a new grant program to combat child, youth, and family homelessness. HHS oversees programs on early childhood, runaway and homeless youth, and other providers with a long history of working together at the intersection of these issues, making the agency a natural place to command and coordinate assistance to end the cycle of homelessness.

This new program should:

- Establish a new funding stream through the agency's Administration for Children and Families (ACF) to allocate funds directly to local agencies, housing authorities, education programs, legal service providers, and others who directly serve homeless children, youth, and families
- Allow funds to be spent on support and prevention services that stabilize families and youth experiencing or at risk of homelessness, such as civil legal aid, housing assistance services, education support, behavioral health services, and more
- Prioritize the allocation of funds to programs serving historically marginalized families of color, pregnant and parenting youth experiencing homelessness, children under age 6, and children with disabilities

It is only when we combine support, services, and system reform that we will be able to achieve a future where every family has a home, a livelihood, and the chance at a better future.

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Big Ideas for the Southwest

Children's Directors' Perspectives

Dr. Tara C. Raines, Children's Advocacy Alliance (CAA)

Ted Lempert, Children Now

Stephanie Rubin, Texans Care for Children

Question 1

What do you think are the three biggest challenges facing children in the Southwest over the next decade?

Dr. Tara C. Raines (CAA):

1. Access to High Quality Health Care
2. Access to High Quality Mental Health Care
3. Access to High Quality Education

Ted Lempert (Children Now):

While there are many challenges facing children in the Southwest over the next decade that will have a profound and cumulative affect on their lives and well-being, we believe the following three, if not addressed with urgency and intention, could not only influence the next decade but could reverse many of the important gains we have made in recent years through additional investments and improvements to the systems serving and supporting kids.

1. Systemic injustices that create barriers to kids, especially kids of color, living in poverty, those who are undocumented and in the foster care system, from growing up healthy and ready for college, career and civic life.
2. The disproportionate impact of the COVID-19 pandemic on the lives of kids, especially kids of color, who are increasingly experiencing stress, social isolation, and disconnectedness causing youth mental health issues to reach crisis proportions. In addition, the learning loss and lack of preventative health care threatens this entire generation of children.
3. Poverty and the widening income divide.

Stephanie Rubin (Texans Care for Children):

We need to make sure more children have the experiences they need during early childhood so they start school ready to learn. Not enough children have access to high-quality child care and pre-k. Not enough children are able to develop the social, emotional, and learning skills they will need in school. To address this school readiness challenge, we also need to make sure that during the first few years of life, more children are getting the health care they need, growing up in households with enough food and financial stability, and experiencing positive, supportive interactions with the adults in their lives.

Children in this region will also face a big challenge when it comes to healthy development. It starts with making sure that moms have access to health care before, during, and after their pregnancy. We also need to make sure children have health coverage to get the care they need. In addition to check ups, medications, and other medical care, policymakers also need to do a better job of ensuring young children get their developmental screenings and receive Early Childhood Intervention services if they have developmental delays or disabilities.

Policymakers must also focus more on children's mental health. For the last decade, we've seen an increase in the number of children with mental health challenges and an increase in the intensity of those challenges. Yet the resources to support children's mental health, both in their schools and in their communities, have not kept up. Better mental health support for children will keep kids safe and healthy, improve learning and behavior in school, and help keep some kids out of foster care and the juvenile justice system.

Question 2:

Thinking about the issues that you just raised, if you had few to no added resources but could transform government or policy, what transformational system changes would you make at the federal or state levels of government to improve the lives and well-being of children in the Southwest?

Dr. Tara C. Raines (CAA):

There are a number of ways in which policy could drive improvements in the three areas above.

First, expansions to children and families who qualify for medicaid and offering continuous coverage for families would be a tremendous asset. This alone would provide health care coverage for innumerable children and youth. With this continuous coverage, policy that regularly assesses market reimbursement rates to incentivize high quality practitioners to relocate and practice in the Southwest would be helpful.

We also believe that policy that identifies metrics closely aligned with programming would be helpful. For example, if measuring the effectiveness of a program for emerging bilingual students, policy should encourage schools to use measures of language acquisition to determine the success or failure of such interventions. It has been our experience that policy with very global requirements for evaluation may result in evaluations that do not directly align with the policy initiative being implemented.

It is also important to note that in all of these areas, we believe strategic workforce development and talent acquisition programs would be beneficial for moving the needle on the areas that impact our children the most. Policies that incentivize talent pipelines leveraging tuition remission training opportunities, investment in higher education, and affordable housing options would increase the number of professions in medicine, mental health, and education in our area.

Ted Lempert (Children Now):

There aren't a lot of system changes that can be implemented without additional resources and there are no "Silver Bullets" that will address and solve the problems that create barriers to the success of our children. However, we believe that the following changes to the many systems — health, education, early childhood, child welfare — that impact and touch the lives of kids can be made within existing resource allocations or with no additional investment but through innovation, creativity, and greater efficiency.

1. Enroll every child in health coverage and ensure they receive comprehensive and consistent benefits.
2. Provide access to culturally appropriate health care providers and reduce the racial, linguistic, geographic and other disparities in children's health care access and outcomes.

3. Focus on the prevention of behavioral health challenges and preventative services in community and school settings.
4. Build on the technological improvements and process simplifications necessitated by the pandemic to make nutrition benefits easier for families to access and use and make school meals free for all students.
5. Improve coordination between Head Start and Early Head Start.
6. Increase the education and experience standards for the childcare workforce.
7. Collect and publicly report data for expanded learning programs to ensure adequate funding to meet the needs of students and address the learning recovery necessitated by the pandemic.
8. Implement state and federal policies that ensure kids of color and kids from low-income families are not disproportionately served by ineffective, out-of-field, and/or inexperienced teachers and monitor the equitable distribution of well-prepared educators.
9. Prioritize school climate and connections with adults on campuses by surveying schools and collecting data to significantly improve students' experiences, ensure non-punitive and positive school climate, and increase student engagement and connectedness.

Stephanie Rubin (Texans Care for Children):

Without additional resources to spend, Medicaid expansion is a great way to make transformational change for Texas families. It's the single biggest step the state could take to reduce the uninsured rate, and some studies show it could be a net positive for the state budget.

Question 3

If you had unlimited resources, what would be the single biggest change in public policy at the federal or state levels of government that would be transformative and game-changing for the children of the Southwest?

Dr. Tara C. Raines (CAA):

With unlimited resources, we would have to focus on funding. We would advocate for an assessment and update of all federal and state funding formulas related to healthcare for children, mental health care for children, and education. Funding for continuous eligibility for medicaid, funding for universal full-day pre-Kindergarten programs, funding for increased school-based and community-based mental health personnel would all be transformative in the Southwest. Looking at policy and allocations in states that perform well on measures of child-wellbeing could offer innovative insight into how to use policy to move the needle in our most dire areas.

Ted Lempert (Children Now):

All children need to have the necessary services and supports — unique to them — to reach their full potential; therefore we have an obligation to ensure that all systems for children are equitable, well-funded, high-quality, and accountable to kids' success. With unlimited resources, we should look to the services and supports that the highest income families secure for their kids across the education and health domains, and ensure that all kids have that same access. For example, the highest income families can choose from among various child care options — home based,

neighborhood based, center based — with costs into the tens of thousands of dollars a year. Public policy should put equal opportunity into practice, and ensure every family has those same choices, with that high quality child care fully funded.

Stephanie Rubin (Texans Care for Children):

Child care, pre-k, and the rest of our early childhood education system is crying out for transformational change. Policymakers should invest in and reinvent the system so that parents have affordable child care options, children get the support they need during this critical stage of early brain development, and child care educators are compensated in a way that honors the important work they do.

Question 4

With respect to your answers to the last two questions, what are the biggest barriers that prevent child advocates from being able to get policymakers to act to make the necessary investments or enact system reforms that would significantly improve the lives of children in this country?

Dr. Tara C. Raines (CAA):

The biggest barriers we face in Nevada, specifically, are perspective and funding. For years, we have performed poorly on measures of child well-being. As such there are many in the public who believe our situation is beyond repair. It has become a part of our collective identity. Targeted efforts to highlight both growth and accomplishment will better help us garner public support for policy to improve outcomes. Second, we cannot stress enough the need to promote policy that considers innovative funding partnerships to promote child well-being.

Ted Lempert (Children Now):

The child advocacy field itself can be a major barrier, when it doesn't effectively harness and coordinate the voices of the thousands of organizations that serve and care about kids along with the enormous public support for kids. When speaking together and assertively, those thousands of groups can push the majority of policymakers to do what they know is right and prioritize investing in kids. But too often, policymakers are pulled away from doing what they want to do by the advocacy of other more effectively organized interests.

Those other interests all employ the same tactics: simple two-word messaging (i.e. pro-business, pro-labor, anti-tax); whole-issue representation; assertiveness; a seamless connection between the grassroots and the inside play. Those interests are successful when they put their often deep conflicts aside and speak in unison to policymakers with unambiguous asks (think companies who are in intense competition with each other, but when it comes to public policy advocacy coordinate around a single message and ask).

Many of the strongest interest groups can also call on a single, massive membership to take action at the right time. These grassroots voices are coordinated with the inside work, and mobilized at the strategic point in time to speak in unison to have the greatest impact. In the kids' field, there isn't one organization with that massive grassroots membership, but, there are examples of the thousands of direct service, parent, youth, civil rights, faith and community based groups successfully being connected to speak at the right time and with one voice on behalf of kids.

Child advocates can and must generate the power needed to truly prioritize kids in policy making by adopting the proven strategies of other interests and changing the equation from zero-sum to more for all kids. We must overcome the scarcity model that means kids of color get less, and the resource competition that fosters the faulty notion that investing more in one area of children's wellbeing means divesting in another.

Stephanie Rubin (Texans Care for Children):

Of course political polarization is an issue. So is the dire need among Texans on so many indicators. On the other hand, we have also seen that when policymakers come together, real change is possible. And that tends to happen when data, the stories of real people, clear solutions, and coordinated efforts to raise awareness happen.

Urgent Priorities for Optimizing the Health, Health Care, and Well-Being of Children

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Over the past decade, dramatic changes have occurred in the way health care for children is conceived and provided, and the next decade is likely to be filled with even more profound shifts. CHIP reauthorization and eligibility modifications have provided more children with health insurance. The Affordable Care Act led many states to expand Medicaid, with some completely shifting from fee-for-service to managed-care Medicaid models, including for children with complex and/or chronic conditions.¹ At the same time, advances in management of many childhood conditions have shifted care from the hospital to the ambulatory setting, resulting in substantial strain on the ability of children's hospitals to sustain full services as margins previously associated with hospital-based care decrease or disappear. Despite these challenges, many children's hospitals continue to develop competitive programs in geographic regions, even for niche, expensive, low-volume specialty care, resulting in inadequate volumes and staffing needed to consistently produce the best outcomes.

These structural changes in the way care is funded are occurring at the same time that our awareness of factors previously largely ignored now take center stage. Passage of the ACE Kids Act in 2019 highlighted the role of adverse events in children's health status and long-term development, yet few health systems are prepared to address these issues in an integrated fashion.² Awareness of the importance of social determinants of health (SDH) is slowly translating into population-health strategies focused on prevention, often requiring partnerships between health systems and childcare, education, housing, and environmental safety and structure. Mental and behavioral health have finally been elevated to a top priority in children's health care, but the infrastructure and funding to support improved outcomes are largely inadequate or inconsistent across local communities, states, and the nation and have been for more than three decades.

All of these changes are complicated by substantial workforce shortages. Multiple child-health specialties have faced workforce emergencies for more than a decade (e.g., child neurology, developmental and behavioral pediatrics, child and adolescent psychiatry, child and pediatric psychology, child abuse, pediatric pulmonology, pediatric allergy and immunology, and genetics).³ These shortages are not limited to specialists; prior to the COVID-19 pandemic, shortages were projected for respiratory therapists; technicians in procedural and surgical areas; and nurses in ambulatory, inpatient, and tertiary/quaternary specialty fields, and these shortages are now acute realities.

These challenges to children's health care are common across the United States, but there is significant variability in how different regions of the country experience and address these challenges. In the Southeast (Alabama, Mississippi, Georgia, North Carolina, South Carolina, and Florida), there are 11.9 million children younger than 18 years old. In three of these states, most children (52%–58%) are white, whereas the other three states have more racial/ethnic minority (51%–59%) than white children. In Southeastern states, childhood poverty ranges from 19.5% to 28.1%, childhood disability ranges between 4.2% and 5.5%, and the proportion of foreign-born children ranges from 0.8% to 6.0%. This region has some of the highest numbers of children who are uninsured or underinsured, with five of six states ranked in the bottom 10 states.⁴ With the exception of Children's Hospital of Atlanta (CHOA), most Southeastern states continue to have children's health care provided by multiple small hospitals and systems, with few incentives for integrated systems of care.

It is time to implement innovative structural, operational, and policy initiatives to address these challenges. In the following sections, we propose transformative change in three major areas of child health: (1) integration of child-health systems within regions to provide close-to-home care

for ambulatory and low-acuity hospitalization needs; (2) collaboration between health systems and other community systems impacting children, including child care centers, schools, housing departments, and parks and recreation programs, to address SDH and improve population health; and (3) innovative inclusion of parent mentors (PMs) to improve child-health outcomes.

Child-Health Networks

Over the past 40 years, health care for many childhood conditions has shifted from inpatient to ambulatory settings. Concurrent with this shift (which also led to increased survival with lower morbidity), an increasing number of children's hospitals focused on providing comprehensive services. This resulted in substantial competition for a shrinking number of children with high-acuity diseases and the duplication of high-cost, low-volume programs in specialty areas such as neonatal care for prematurity, congenital heart disease, transplantation, and oncology. Care for diseases that traditionally had filled inpatient beds (such as asthma, respiratory syncytial virus, sickle cell disease, cystic fibrosis, and some childhood cancers) shifted to ambulatory settings, unintentionally resulting in reducing hospital financial margins; comprehensive staffing for hospital-based programs; and ultimately, patient volumes needed to sustain the best outcomes. At the same time, few communities or child health networks were positioned to transition to high-quality, comprehensive, wraparound care needed in ambulatory settings.

Several factors contributed to these changes. Reimbursement for services, both hospital and physician, has historically been skewed toward performing surgeries and procedures and filling beds. This led to business models emphasizing specialty, tertiary/quaternary care to generate margins needed to support comprehensive, non-specialty-based services (many low reimbursable or non-reimbursable) needed for all other types of care. Because government-insured health care permitted higher charges (e.g., facility charges) for inpatient care, the business plans of many health systems focused on prioritizing surgeries and procedures done in inpatient settings, even if those services could be performed safely and at lower cost in ambulatory settings. This produced financial margins necessary to underwrite ambulatory services that often serve as feeders to hospital-based practices.

This model of care and financing is under siege. Ambulatory care previously reimbursed on a fee-for-service basis has increasingly shifted to managed care or risk-based contracting, with a focus on value-based payments for outcomes instead of unit-based health care activities. The Affordable Care Act includes provisions that are leading to diagnostic and interventional procedures and surgeries that can be safely performed in ambulatory settings to be reimbursed at lower, non-hospital-based rates. For many, these are welcome changes that improve care at lower cost, including prevention of disease or condition severity. These changes, however, present potential adverse challenges, including the financial viability of comprehensive, wraparound care for children in the ambulatory setting; the sustaining of a multispecialty workforce for both inpatient and ambulatory care; and the overcoming of historic competition and animosity among children's health systems within regions. Thus, although the vision of a new system of children's health care that is largely ambulatory, comprehensive, integrated, accessible, prevention focused, and lower cost is exciting, the reality of how to transition to this new vision and sustain it financially is not simple.

Health systems, hospitals, and health care providers adjust to how services are reimbursed. Current policies that prioritize surgery, diagnostic and interventional procedures, and critical care produce strategies to optimize those activities. Government-funded insurance that provides

substantially lower reimbursement for professional services (e.g., Medicaid vs. Medicare models) stresses or makes impossible the concept of comprehensive wraparound care and creates intense competition for commercially insured children. This model works for adults, for whom the volume of patients with any given condition supports multiple competitive practices, but fails for children, who have a much lower burden of moderate to severe disease, resulting in not enough patients to support a high-quality, excellent-outcome, competitive system. At one point, most states required a certificate of need for specialty children's programs, which facilitated regional consolidation of the high-cost, low-volume services, but over the past years, state legislatures have abolished or diminished certificate-of-need requirements, leading to the creation of multiple small programs, sometimes with disastrous outcomes.⁵

Some regions of the country have addressed these issues by creating large children's health systems, resulting in a dominant regional provider's capitalizing on commercial insurance contracts and regional philanthropy for children's health. Others have attempted mergers of smaller children's hospitals, which are fraught with challenges. One exception is CHOA, the result of a merger of Emory University, Eggleston Children's Hospital, Scottish Rite Children's Hospital, and Hugh Spalding Children's Hospital at Grady. This merger was supported by the local community with substantial philanthropic donations, a gradual transition plan for staff and services, closely integrated affiliation with an academic partner, and a plan allowing long-standing hospitals with rich traditions in local communities to maintain their local identities.⁶ The outstanding outcomes following the successful creation of regional child health networks are well documented.

The CHOA model was developed in an era before the Affordable Care Act, wide expansion of competitive children's hospitals, and advances in care that changed the nature and number of children requiring acute inpatient care. We believe it is time for an innovative "big idea" vision for optimizing children's health care, and we propose the following:

1. Federal and state policies are needed, incentivizing hospitals, primary care, specialties, subspecialties, and communities to create partnerships that consolidate high-cost, low-volume, often duplicative tertiary and quaternary care within regions. This will produce volumes necessary to comprehensively staff the programs with highly trained and expert teams.
2. Federal and state policies for child health insurance need to be modified to reimburse systems of care, as opposed to discrete health care activities, so that a comprehensive inpatient and ambulatory child-health infrastructure can be sustained. History suggests that changes in government-based payment systems will be followed by commercial insurance.
3. Federal laws designed to reduce fraud (e.g., the Stark Law) need to be reviewed, and special provisions for children's systems must be developed that reduce barriers to integrated care across the child-health spectrum. Abuse concerns that these regulations address are rare in children's health programs, largely because of the small volumes, and serve as barriers to strategic, systemic improvements in children's health care. This policy change would support integration of activities across the spectrum of prevention, population health, primary care, specialty care, inpatient tertiary/quaternary care, and rehabilitation.
4. Federal and state funding for children's health must require and fund access to services for behavioral and mental health services at sustainable parity levels and incentivize full integration of mental and behavioral health services into primary, specialty, inpatient, and rehabilitation care.

5. Federal and state support is needed for transition from current diffuse, competitive care models to integrated care models. Changing systems will require more than incentives, and underwriting transition costs is essential. In addition to direct government support, enhanced, targeted tax benefits should be explored for philanthropists and corporations that provide donations for transition costs and capital needs related to integrated child-health systems within regions. This is perhaps the most important of all policy considerations in our big idea.
6. Long-term, federal and state policy shifts that facilitate funds-flow across agencies are needed. Our growing understanding of the role of SDH makes it imperative that children's health be addressed in collaboration with agencies responsible for education, housing, employment, child care, recreation, and environmental safety. Resources strategically invested in these areas can have profound benefits in reducing health risks and use of health care resources in future generations, including prevention of costly adult diseases.

Policy changes, funding transition costs, and incentivizing collaboration and partnerships across hospitals and practices are all necessary features of a transformed child-health system, but these are not enough. Successful transformation will require existing health systems' changing their views from competitive to collaborative, community leaders' and communities' embracing the concept, and respecting local identities and loyalties during transformations. Most of all, evidence of improved outcomes for children's health will be essential at every step in the process. Specific suggestions for programmatic change are included in the following components of our big idea.

Early Child Development and Population Health

A Robert Wood Johnson Foundation expert panel concluded a decade ago that investing in early childhood development is the best way to improve the health of all Americans.⁷ The Centers for Disease Control and Prevention has also long identified addressing adverse childhood events (ACEs), such as substance use and child neglect, as essential to reducing the burden of heart disease, stroke, and cancer among adults (see Figure 1).

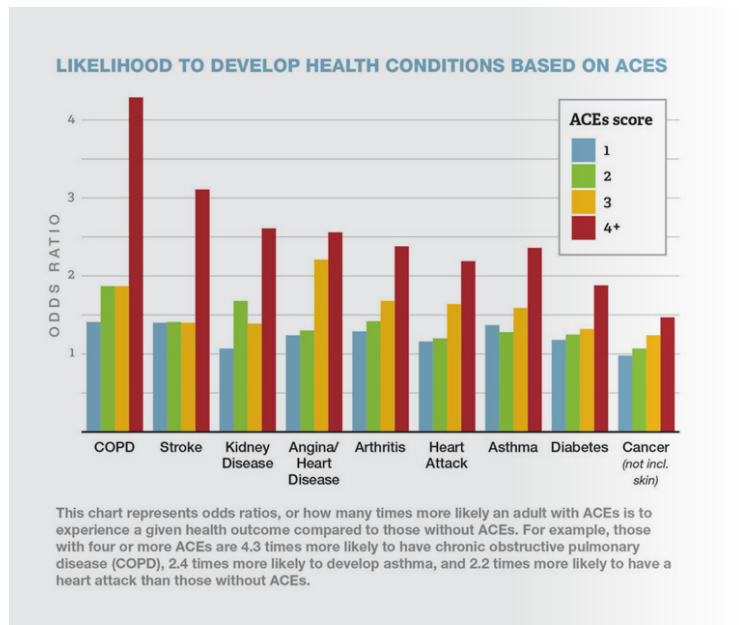


Figure 1 (Note: ACEs = adverse childhood events)

Disrupted neurodevelopment is a critical step in the path from ACEs to adult mortality (see Figure 2) and is an area where intervention can substantially improve outcomes.

In one randomized controlled trial (RCT) of two years of high-quality early child education among children at high risk of poor outcomes, participants were much more likely than waitlist controls to enjoy economic security, achieve academic success, and avoid the criminal justice system in follow-up studies that extended to 40 years later.⁸ Addressing SDH in the first five years of life is the best investment a society can make, according to Nobel Prize winner James Heckman.⁸

Despite recognition of the importance of SDH in early childhood for the health of people across the lifespan, the health care sector has had limited success in directly addressing these environmental drivers of health. One long-standing reason is that payment mechanisms discourage investing in disease prevention and health promotion. Under traditional fee-for-service payment arrangements, health care systems are economically most productive when children with asthma make frequent physician and emergency-department visits, are hospitalized, and are admitted to intensive care units. There is no financial incentive to work with families on asthma action plans, include school nurses in action plans, confirm children obtain needed medications and know how to use them, and ensure that children reside in allergen-free homes in neighborhoods with clean air. During the early stages of the COVID-19 pandemic, when children were not admitted to hospital except in extreme emergencies, administrators feared for the financial viability of their institutions because beds were empty and income streams stopped. Such is the economic logic of fee-for-service payment arrangements.

Adult health care systems are moving toward value-based payment mechanisms that reward health care organizations for improving outcomes and not merely providing discrete services for individual payments. Such financing arrangements have been more difficult to implement for children, especially those covered by Medicaid.⁹ Children are healthier, on average, than adults, so there are fewer opportunities for health care cost savings; benefits of improved child health and development accrue to other systems (education, juvenile justice, and adult health care) and are generally long term (i.e., reduced adult morbidity decades later);¹⁰ and children with medical complexity account for much of a health care system's costs because their care is expensive. Perhaps most important, improving child health outcomes is generally beyond the capacity of clinicians because they have limited ability to influence SDH. Pediatricians can easily screen for family concerns, such as unemployment and homelessness, but this fails to address the underlying social and economic conditions at a population level.¹¹

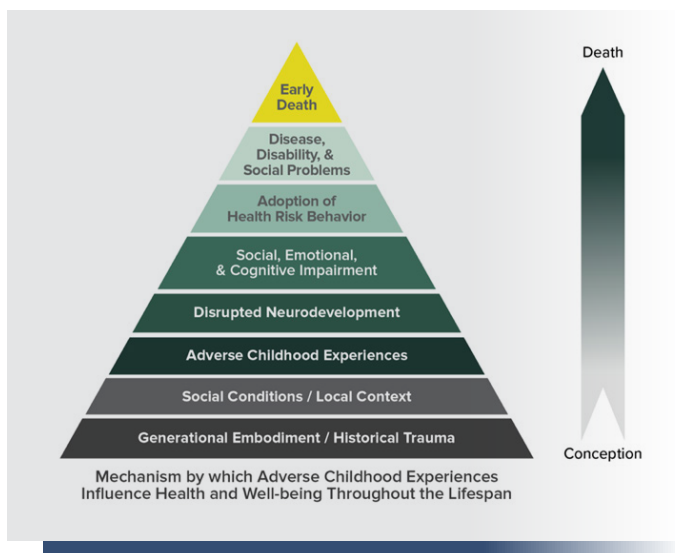


Figure 2

One exception is Partners for Kids, the accountable-care organization affiliated with Nationwide Children's Hospital in Columbus, Ohio, in which the health care organization collaborates with community partners on job training and improved housing in neighborhoods around the hospital.¹² In another example, the Mailman Center for Child Development in the Department of Pediatrics at the University of Miami Miller School of Medicine partnered with leaders of community-based coalitions in two neighborhoods adjacent to the health care center. This decade-long collaboration was associated with improvement in early childhood development, compared with control neighborhoods.¹³

Medicaid policy has the potential to make such examples the norm: health care systems could aim to improve child health and development rather than depend on children's being sick for their financial viability. Medicaid is an especially powerful lever, as nearly 40% of U.S. children are enrolled in Medicaid,¹⁴ and they represent the children most affected by SDH and ACEs. As noted above, the transition to value-based care can be difficult in Medicaid populations, though states such as Ohio have successfully moved most children in Medicaid to such payment arrangements. The danger in this shift to per-member-per-month payment schemes is that managed care organizations (MCOs) and health care providers are financially motivated to not provide medical care. To avoid such an outcome, state Medicaid agencies carefully monitor health care measures, such as the Healthcare Effectiveness Data and Information Set and the Medicaid Core Set. Financial penalties for failing to provide high-quality care can mitigate incentives to limit health care services. Although useful for ensuring needed care, such as immunizations and well-child care visits, such process measures do not address the deeper elements of child health and well-being.

One big idea is to provide financial incentives to MCOs and health care providers to improve child development at a population level. For example, what if state Medicaid contracts included additional payments to MCOs if an objective measure of kindergarten readiness improved each year? Rewarding MCOs for focusing on early child development would bring the vast resources of the health care system to disrupt the mechanism by which SDH lead to poor outcomes. Most MCOs already recognize addressing SDH is essential to reducing their members' health care costs and offer a variety of enhanced or in-lieu-of benefits to support families and prevent illness. Providing MCOs financial incentives for early child outcomes would more directly reward their efforts to mitigate SDH and even prompt them to address socioeconomic and political issues underlying community-level health disparities.

What might MCOs actually do to invest in early childhood development? They could work with clinicians to ensure evidence-based activities, such as Healthy Steps¹⁵ and Reach Out and Read,¹⁶ were as routine as vaccinations in pediatric offices. Parenting interventions, such as the Incredible Years¹⁷ and Parent Child Interaction Therapy,¹⁸ would be essential benefits, and there would be seamless referrals to child-development programs such as Part C Early Intervention and Part B Special Education. Home visits by nurses or PMs would be financially rewarded. MCOs would have strong incentives to partner with community organizations to address poverty, homelessness, and other SDH.

Data to measure child development are already available at the population level. In Florida, for example, state law requires that a child-development screening instrument, the Florida Kindergarten Readiness Screener, be administered to all public-school kindergarten students within the first 30 days of each school year.¹⁹ Population-level data are publicly available by zip code and could be used to measure improvement in geographic areas where each MCO has enrollees. By using population-level data, rather than outcomes for individual children, MCOs

would be incentivized to collaborate with community partners to address underlying SDH. By rewarding annual improvements rather than high levels of kindergarten readiness, MCOs would be incentivized to invest in neighborhoods with the greatest potential for change.

There are challenges to such a novel approach to health care financing. A first step would be convening MCOs and community partners to ensure alignment of goals and incentives. A successful regional pilot program would start with transparent and meaningful engagement of families (health care plan members), community and political leaders, local anchor organizations, and representatives from other systems that impact child development, such as education, housing, employment, public safety, and community planning. Fortunately, many communities already have children's service councils that serve to coordinate activities on behalf of children and the people who care for them. One key issue would be careful analysis of the specific measure (e.g., kindergarten readiness) to ensure agreement that it is a reliable and meaningful way to gauge outcomes. Another issue would be how to apportion MCO responsibility (e.g., number of enrollees in a defined geographic area); with multiple MCOs in a given neighborhood, a mechanism would be needed for identifying who gets the credit.

Medicaid financing is one of the most powerful mechanisms that state and federal governments have to improve child health and well-being, especially among children who face challenges because of poverty and other SDH. As health care systems transition to value-based arrangements, health-policy leaders have the opportunity to align financial incentives that promote child development and have the potential for enormous long-term impact. Financing geographically focused demonstration projects is a good way to explore how best to align health care payment arrangements with outcomes that matter most to children and the people who care for them as well as broader society.

PMs

Overview

PMs are parents who already have a child with a condition or health care challenge who are trained to help other parents with a child with the same condition or health care challenge. PMs receive training on the following:

- **Helping parents and their children better understand, treat, and manage their condition or health care challenge** by leveraging PM experience and training on how to successfully care for children with these conditions and challenges
- **Teaching parents to be “health care literate”** by assisting them with securing medical homes, dental homes, subspecialty services, a regular pharmacy, and ancillary health care services
- **Assisting families with addressing SDH** by screening for SDH and connecting families with appropriate programs and resources such as food pantries, housing agencies, and legal assistance with immigration issues

PM Benefits

PMs are a transformative “big idea” because they are documented in multiple studies^{20,21,22} to be effective in achieving (1) significantly better health outcomes, (2) improved access to primary and subspecialty care, (3) reduced unmet needs, (4) lower parental out-of-pocket costs and family financial burden, (5) enhanced parental self-efficacy, and (6) substantial cost savings for society. PM programs also create jobs and empower communities to help themselves.

PM Evidence

Two RCTs have demonstrated that PMs are a highly efficacious and cost-effective intervention for improving health outcomes and eliminating disparities.^{20,21,22} An RCT of the effects of PMs on minority children with asthma showed PMs are significantly more effective than traditional asthma care in reducing rapid breathing episodes, asthma exacerbations, and emergency department visits but cost only \$60 per patient per month and save \$597 per asthma-exacerbation-free day gained.²⁰ For children and families with the highest intervention fidelity (attending $\geq 25\%$ of community meetings and completing $\geq 1/2$ of PM phone interactions), additional intervention benefits included significant reductions in wheezing episodes and missed school and parental work days and significantly higher parental self-efficacy scores in knowing when a child's serious breathing problem is controllable at home.²⁰ Participant and community stakeholder feedback on asthma PMs was laudatory.²³

Another RCT (Kids' HELP) of the effects of PMs on insuring uninsured minority children documented that PMs are significantly more effective than traditional Medicaid/CHIP outreach and enrollment methods in insuring uninsured children; obtaining insurance faster; renewing coverage; improving access to primary, dental, and specialty care; reducing unmet needs and out-of-pocket costs; achieving parental satisfaction, improving well-child-care quality; and sustaining long-term coverage.^{21,22} PMs also were inexpensive, costing \$53 per child per month, but saved \$6,045 per insured child and created jobs in minority communities.^{21,22} Based on these savings, estimates indicate that national implementation of PM interventions to insure all Medicaid/CHIP-eligible uninsured children could save the United States \$17–20 billion.²¹ Participants and community stakeholders enthusiastically praised Kids' HELP.²⁴

PM Policy Achievements

The strong evidence base for the effectiveness of PMs resulted in a section in the 2018 CHIP Reauthorization²⁵ signed into law by the president and Congress authorizing \$120 million in CMS funding for PMs to be used for outreach to and enrollment of uninsured children eligible for CHIP and Medicaid.²⁶ This legislation has resulted in funding PM programs in seven states (Arizona, California, Florida, Michigan, Oklahoma, Texas, and Washington) and the Cherokee Nation in the first waves of grants.^{27,28}

PM Policy Opportunities

Rigorous RCTs have demonstrated PMs' effectiveness in improving child health and health care for those with asthma and who are uninsured. There are many opportunities to leverage the power of PMs to improve outcomes for children living with the spectrum of conditions and health care challenges (see *Table 1* on page 103).

Promising federal policy opportunities include legislation funding programs focused on each of these conditions and blanket legislation allowing for funding of overarching PM programs that could be customized according to individual state priorities and needs.

There also are several promising state policy opportunities. First, legislation is needed to formally classify a PM as a type of community health worker. Second, certification would be needed to document that a PM has completed the necessary training. Third, legislation is needed that would allow reimbursement for PM services through health plans, including Medicaid, CHIP, and private payers. CPT codes (98960-2) already exist that would facilitate this (e.g., CPT 98960: “Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient [could include caregiver/family] each 30 minutes; individual patient”). And fourth, states could appropriate funds to create and pay for PM training and certification programs, thereby creating jobs that would benefit underserved communities.

Final Thoughts

We have proposed the rationale and evidence for three big ideas that have the potential to transform the child-health system and improve outcomes for children and the people who care for them. In each case, we focused on how policy changes to the health care system are necessary to realize the potential of our nation’s children. In the first example, regional integration of child-health systems could improve close-to-home care for ambulatory and low-acuity hospitalization needs and lead to more appropriate use of resources. In the second example, choosing the right outcome measures for Medicaid MCOs can harness the enormous resources of the health care system to directly address SDH and improve population health. In the final example, relatively small-scale changes in health care policy financing to include PMs could have substantial impact on child health, family well-being, jobs creation, and society cost savings. These big ideas offer complementary paths forward to improve the child health care system and promise societal benefits with both short- and long-term returns on investment.

Table 1. Opportunities for Leveraging Parent Mentors (PMs) to Improve the Health and Health Care of Children.

Condition/Challenge	PM Example
Allergy/immunology	PMs assisting families with children who have immunodeficiencies
Behavioral-health issues	PMs helping families with children newly diagnosed with behavioral-health disorders
Cardiology	PMs supporting families who have children with congenital heart disease
Complex chronic conditions	PMs assisting families with children who are technology dependent
Critical care	PMs helping families admitted to intensive-care unit to address challenges and transition to home
Developmental/behavioral pediatrics	PMs supporting families with children with autistic spectrum disorder
Endocrinology	PMs assisting families with children newly diagnosed with diabetes mellitus
Gastroenterology	PMs helping families with children with inflammatory bowel disease
Hematology/oncology	PMs supporting families with children newly diagnosed with malignancies
Homelessness	PMs assisting homeless families with finding housing and addressing other SDH
Hospital readmissions	PMs helping families whose children are being discharged from the hospital to implement measures to avoid rehospitalization
Infectious disease	PMs supporting families with infants born with congenital infections
Neonatology	PMs assisting families with premature or low-birthweight infants
Nephrology	PMs helping families with children undergoing renal transplants
Neurology	PMs supporting families with children newly diagnosed with epilepsy
Pulmonary	PMs assisting families with children with cystic fibrosis

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A Conversation with PASOs

Supporting Community Health Workers in South Carolina's Latino Communities

Maria Martin and Agner Muñoz, PASOs Programs

Introduction

In April 2022, Carrie Fitzgerald and Miriam Abaya of First Focus on Children spoke with Maria Martin and Agner Muñoz from PASOs, a South Carolina-based organization supporting Latino communities through education, advocacy, and leadership development. Maria is the executive director of PASOs, and Agner is a community health worker and the Midlands program director. In this interview, Maria and Agner told First Focus staff how PASOs was founded, their model of work, and the many ways that they empower Latino families to support their children and broader community. PASOs' successful model not only displays a best practice to ensure that Latino and/or immigrant families get access to the services they need, but also gives a case study of how federal, state, and local policies can better support community-based organizations and the families they serve. This paper is the transcript of the conversation with Maria and Agner and offers policy solutions to ensure that children in Latino and mixed-status immigrant families have what they need to thrive.

The conversation is edited for clarity.

Miriam:

Maria, tell us about PASOs' history and why the organization was founded.

Maria:

PASOs was founded in 2005, when the organization received its first funding to hire its first employee. However, PASOs really started with a thesis and research done by our founder [Julie Smithwick] while she was getting her master's in social work.¹

At that time, in the late '90s and early 2000s, there was a large increase of Latino immigrants into South Carolina, as much of the Southeast at that time experienced. South Carolina's Latino population grew at a 200% to 300% rate. Very quickly it became clear that our system was not meeting the needs of individuals and families that were now calling South Carolina home. So our founder embarked on a study to specifically investigate the needs of pregnant women, how the health system was meeting their needs in terms of having happy, healthy babies, especially the process of prenatal care and birth.

In that study, [Julie] was able to identify the gaps in service — what the needs were — and come up with a response. She had lived in Ecuador for four years through the Peace Corps and was herself a community health worker in Ecuador, so she became very familiar with the strengths and positive impact of community health workers. Having these workers reach local communities, better connect them to resources, and help them understand how to navigate resources available to them was beneficial for families to live a more wholistic life, improve their well-being, and help them thrive. So, her response was mirrored after the community health model, and that's how we got started.

From then on, our Latino community continued to grow, and families and individuals stayed in South Carolina. And therefore, the need stayed. From there we grew to identify more needs for families, got funding, and started having conversations with our systems of care about this need and how we can help as an organization to bring our system up to understand how to work with Latino individuals and families, how to meet them where they are and provide services in a meaningful way that makes sense to them. We've grown since then, and now have a statewide network of PASOs community health workers.

Miriam:

As you mentioned, one of the key areas of PASOs' work is working with systems of care to build their capacity. Can you tell us more about the gaps in systems of care and how PASOs helped improve capacity to work with the Latino community?

Maria:

Our direct work is to inform the community, the grassroots piece of working with actual Latino individuals and families. Families are participants: we feel they are an equal part of the solution. They're the experts in themselves, in what they need, and in how we can meet their needs. That impacts how we do our work of helping them understand how to navigate resources and systems in South Carolina. We felt that our direct work helps our Latino communities better understand how to have access to services, voice their needs, and understand how things work here. But what we quickly learned was that our social services, health, and education systems were not ready to serve these families. It's still a work in progress in terms of understanding the cultural diversity of Latino families and how that plays into the way we offer services — sometimes there is a disconnect. Very specifically, language is an issue. Our systems are not ready to have things translated into Spanish, do not have bilingual, bicultural staff or translation services. That's just the first barrier of community and service provision.

We found there was so much we could do by offering cultural competency trainings and bringing together organizations who are working with families to share amongst each other and learn from each other on strategy. How do we change certain protocols? What are the requirements or criteria to access our services? Is there a way to modify those so that we are more friendly to families and make sure that Latino families meet our criteria and can qualify for our services?

Miriam:

As you mentioned, the heart of what you do and what you are communicating to these systems of care is working directly with families. Tell us more about your two key programs — the PASOs Health Connections Program and the Childhood Development Program — and how they support families.

Maria:

I joined PASOs in 2014. At that time, we received funding to begin to work with early childhood organizations in our state and started having conversations with their task force and coalitions about how to reach Latino parents and help them understand the education system and help their children be ready for kindergarten. Those conversations increased awareness of the many other challenges for Latino immigrant families to understand how things work in South Carolina and how they can better support their children in their development. There is a cultural difference from their own countries of origin in terms of preparation for a child's education. Since PASOs started, we've worked with families where moms had happy, healthy babies, and then they asked us, "Now I have a baby, but I don't know what to do. How do I best care for my baby?" This was especially a question for those first-time moms. So PASOs started engaging and doing research to start an early childhood program with Latino families.

Young Latino Children in South Carolina

- 10% of all parents of children ages 0–10 in South Carolina are immigrants.²
- Latino children currently represent 10% of South Carolina's children ages 0–5, and in some counties over 25%.³
- Of immigrant parents in the state, Latinos make up 57% of parents of children ages 0–4 and 59% of parents of children ages 5–10.⁴
- Immigrant parents are a disproportionately large share of all low-income parents of children ages 0–4 in South Carolina at 14%.⁵
- Immigrant parents make up 20% of parents of children ages 0–4 who lack access to the Internet — a disproportionately high number.⁶

We have several programs. We have a parenting program which promotes positive parenting and provides support for parents with children. We've also developed the Connections for Child Development Program, which is now very active. This program comes alongside parents and caregivers to assess a child's development, focusing on children from zero to five. We use the ASQ-3 tool and the SE tool⁷ to gauge the child's development. This is also an opportunity to work with parents and let them know how they can support their child's development based on the results of the screening.

Often, we find we can celebrate with parents about the great work they are doing, and we leave behind tools and education about early childhood specific to the age and stage the child is in. Importantly, there's also early identification of any red flags, and we can connect families with further assessment for their children. The assessment we do is just a window into what is happening with the child. After that, we can connect a family with resources and experts who can do further assessment and ensure early detection of anything that might be wrong and all the steps that must follow once we identify something.

The Connections for Child Development Program is our most active program right now. But we also make sure parents feel informed. We support them in other areas, such as in education. I'm sure Agner can speak to the many, many times that his team or other community health workers across the state have engaged with families who need our support to communicate with schools about what's going on with their child and how they can be a supportive parent. Our families are often misunderstood as not caring. But for Latinos, our children are everything. It's just that things work differently in the country of origin that the family comes from, where teachers and school, not parents, play a larger role in education. Parents just need more information and a better understanding of the systems here.

Miriam:

I'd love to hear from both of you, Maria and Agner, about the population of Latino and mixed-status immigrant families in South Carolina. What are their lives like, and what have been areas of successes and struggle for them?

Maria:

As I mentioned earlier, there was fast growth of the Latino population in the '90s and 2000s. It's plateaued, and Latinos currently make up around 6% of South Carolina's population. We have pockets where there are more Latinos than in other parts of the state — for example, we have a big presence in the Lowcountry in Beaufort, Jasper, and Charleston counties, and in the Greenville area, which is upstate. We have a strong presence in the Midlands area as well.

A lot of our families come from Mexico, but we do have strong presence of Guatemalans and Colombian families. Agner is hands-on with our community members, so he can tell you a lot more in terms of what the challenges continue to be and what some of the successes have been. He's worked with the community and has been with us for some time now.

Key Facts about Latinos in South Carolina⁸

- South Carolina was ranked number one among all states in Latino growth in 2010, experiencing a 300% increase from the 2000 census.
- South Carolina is home to approximately 87,000 people who are undocumented, 64% of whom are of Mexican heritage.
- A Latino family earns an average income of \$39,219 in South Carolina.
- Latino students make up almost 10% of the K-12 student population.
- Of Latinos in South Carolina, 37% are uninsured.
- Only 18% of South Carolina mental health facilities offer services in Spanish.

Agner:

I'll stick to the population that we serve here in the Midlands, as it varies from county to county. Here in the Midlands, we encounter families who live in trailer parks, usually with more than one family in one trailer. It's crowded, and these areas are not as beautiful and safe as they should be. The streets have potholes, there are no lights, and there are no recreational areas for the children. These families' daily lives are not as "beautiful" as they should be.

But you have to consider what these families faced in their countries of origin and the struggles that led them to decide to leave their family, friends, and beloved country and come here to live a new life, even in the situations that they live in now. I've been amazed by their resiliency and strength. It's hard to see them live in these conditions, but for them it's better than living in their home country. Because the crime rates, the gangs, the narco-gangs — those situations forced people to leave. Their strength comes from that experience: they will do whatever they need to do to sustain and keep their families here. That's their major strength.

Struggles include language barriers and the lack of access to services that the state offers, as Maria was talking about. Some of them don't qualify for services. So that's their main struggle. But in the midst of that, their strength and areas of success are their love for their family and the resiliency

they show on a daily basis. These people come here to work, to lay their bodies out there for their families, for the love of their family. So that encourages me. I'm a better man and a better human being experiencing life with them.

Carrie:

Agner, could you share what brought you to this work? What brought you specifically to the PASOs program?

Agner:

So, most of us, we knew PASOS or we know PASOS because we were participants before being employees. I arrived here in South Carolina back in 2017, after Hurricane Maria destroyed my house and my personal belongings in Puerto Rico. So, my wife and I just decided to move from the island because the situation was very bad. We have a son who's 7 years old. He has a mild autism. In Puerto Rico, sadly, there are no services or public services for this type of condition. So we were really deciding to move off the island, but the hurricane sped up the process for us. We came here to South Carolina, and we were struggling to find services, to find programs for him. Both my wife and I are bilingual, and we have a college education. So you can imagine how it is a struggle for other people that don't have our education and don't speak the language. We were struggling as well.

One day, I was in a Prisma health facility — actually, it was an appointment for a developmental pediatrician for my kid. And we, my wife and I, we were just talking Spanish, and this lady was sitting right in the office where we were. And she came in and she introduced herself as from PASOs. Actually, I'm her supervisor right now. And she told us about what PASOs was doing here in this state, and how her program, which is the Connection to Child Development, can help our kids. Then she asked us about Spanish family services, and we had the visit. Lulu did the assessment for my kid. And that's how we started the process.

I can tell you, and I'm very proud of this. My kid was nonverbal when we arrived here in South Carolina. And thanks to the intervention of Lulu, PASOs, and the connections that she made for our kid, now Mikey can't stop himself from talking. Now he talks or counts in five languages; he talks in Chinese, in French, in German. I experienced the success of our CCD connection program ourselves. I can see it, we experienced how the early intervention process can help an autistic kid to thrive here in our education system.

This is something that I feel proud of, because now I'm part of this.

Back in Puerto Rico I was working with disadvantaged populations or communities. I was an athletic director for a private college. But my main reason to work there was not winning championships. I was just helping young student athletes from these disadvantaged communities have the opportunity in life, to get out of those bad neighborhoods, from the gangs, and be someone in life. So, my love for disadvantaged communities, for the whole community in general, was born back in Puerto Rico. And when I came here, and then had the chance to interview to do something for communities here, it was like, oh my gosh, this is the perfect environment for me. And this is not a job, this is not work for me. This is just a chance to give back in life, basically.

Maria:

The majority of our community health workers who were recruited to work for PASOs were first participants.

Carrie:

Can you tell us a little more, Agner, about the day-to-day work of the community health workers? What is it like to be a community health worker there on the ground?

Agner:

This is the best thing I have ever done in my life. As I was telling you, this is not a job for me. This is like a mission in life now. On a daily basis, we interact with different Hispanic families from different countries. We receive calls, we receive referrals, we are outside in their communities, we do home visiting. We experience their struggles, we help them navigate our system, we provide education on how to navigate the system. This is something very important: we do not carry our people, we support them. That's why we call them participants. They are part of the process on how to learn, how to navigate, and how to thrive here in South Carolina. But it's an awesome experience — on a daily basis, you encounter people, you get encouraged, and you're amazed by the resilience of our people. This is something that you see every day.

Sometimes I face situations with these people that, if it was me, I don't know how I would handle those situations. They just, this is a new challenge for them. And they just go through the process and they embrace the process. We see them thrive and succeed in this environment. It is just awesome and so encouraging for you as a human being; it just makes you grow as a human being. To experience the struggles and see these people thrive through this experience is just awesome. This is the best experience, it's not a job. For me as a CHW, a community health worker, it's not a job. It is just something that you feel grateful to do.

Carrie:

It sounded like, from some of the things you've described and that Maria described about what community health workers do, such as home visiting, that they go to participants' homes and meet them there and maybe at their kids' schools, that kind of thing? Do they coordinate medical appointments, or how do they get folks into the medical system?

Agner:

The majority of the home visiting actions that we do are in this Child Connection Development program, because we try to assess or screen these children in their home in their natural environments so they can behave in a natural way, instead of in another place or a clinic. We can also do this screening in parks or out in public if they feel more comfortable doing that. But we prefer to do it in their home, because this is going to show how the child will behave in a natural way. But through the process of visiting these families to assess or screen their child, that's when you face or find out the other struggles or the other needs that the family has. For example, some of these families don't have a family practitioner, particularly a doctor or medical doctor or a family doctor. So, you connect them with clinics or doctors here that will accept or see these persons without insurance or without money to pay for their visits.

Let's say they have been struggling with food insecurity, so you connect them with food banks, or you provide them with donations from organizations like a bag of rice or oatmeal. We provide them with those things whenever we have them. Let's say they need assistance with their rent. We know the resources around the state that they can benefit from. So, we connect them and we help them through the process. Through a visit that at first was just to screen the kid, you've helped them with so many things that you will find out through the interview process and interaction with these families.

Maria:

We did create protocols and a process map for that model, which is our flagship program called PASOs Health Connections. And this is where we engage with families to identify each and every one of their needs, starting with what's priority for them, and helping them understand, educating around whatever topic it is, and then connecting to those resources and understanding how to navigate the resources. So, we're addressing social needs, and in instances related to health we're addressing the social determinants of health. If somebody doesn't have transportation, then because of that they can't get to their appointments. It's somebody who's diabetic, and they don't understand what foods they need to eat. There's so much that happens.

The Landscape of Health Care Coverage in South Carolina

- Healthy Connections provides health insurance plans for children who live in families with income at or below 213% of the Federal Poverty Level (FPL).⁹
- South Carolina covers lawfully residing immigrant children and pregnant people in Medicaid and the Children's Health Insurance Program (CHIP) without the five-year waiting period.¹⁰
- South Carolina has not expanded Medicaid for adults and offers Medicaid coverage to nondisabled adults up to only 67% of the FPL.¹¹
- South Carolina provides 12-month continuous eligibility for children in Medicaid and CHIP.¹²

For example, a mom has a child that one of our CHWs is helping assess, and while doing that, they find out that mom has diabetes and that she really hasn't gone to her doctor visits because there are other needs such as no transportation or there's just other things going on; the community health worker is able to sit down with them and start prioritizing what's most important and how do we address each of the needs. How do we continue? So, we'll follow through, and we are very proud of our closed-loop pathways that we create, based on each of the needs that the families have: opening it, addressing it, and then closing it by making sure the needs and goals the family set for themselves were met.

Agner:

Even though they are two separate programs, the PASOs Health Connections and the Connections for Child Development, they are not separate in the daily work. They interact. As I was already telling you, you can't separate one thing from the other. When you are screening a kid, you will find out that the family is struggling with something else. And the other way around, if you are helping this family with this situation that they have, a social issue that they have, and you keep

asking them, they will tell you, "I have a 4-year-old kid who is not in school, is not speaking." So, there's no way to separate this from the lives that they live.

Maria:

And the outreach really happens in many different ways. We really leaned on the social media activity we already had going on pre-COVID. But it became pretty much the only way, for almost a year, that we were communicating with families, because of all the COVID-19 restrictions. We also heavily relied on the phone communications we still had with people. We focus so much on doing our work through our values of equity, trust, *compromiso*, which is a commitment with community to serve. And with all these values that we have in place, we were able to stay connected. But it really happens in many different ways, shapes, and forms. We still have outreach events at places that are frequented by the families that we're serving. We go house to house sometimes. It just depends on each site, and what they feel is the need in terms of staying connected with community.

Carrie:

Thank you both for explaining that. You can just see how it's really about building relationships and trust. And as soon as a family opens their door to you or meets you in a park, you learn about the whole family, you can't just be there for one reason. So, thank you for giving those great examples.

You've both referenced a couple of things. Miriam and I work on policy, we want to change policy to help kids and families. We heard you say some things about language barriers, transportation barriers, other things. What else do you think families really need in order to be healthy and get the services that meet their needs for their families? What else should we be thinking about?

Agner:

I believe they need to feel the support from the system. They don't feel that encouraging feeling that the system is trying to help them. It's a struggle most of the time. And you can include the language barrier. If there's a genuine interest to help these families, the system should have or must have language access for them, interpreters, info fliers in Spanish, and not all the organizations, programs, services, or systems here in South Carolina have that. They don't show that. So, the people just don't feel supported, just because they don't have the information in their home native language. Even though we encourage them to learn English, to learn the language as part of our education process as well, part of our values, we just encourage families to be better. Then if they decide to move to a country that speaks a different language, we encourage them to learn the language. But we must keep in mind that these people come from different countries where their education system is not as good as others. Maybe they don't have the tools, or they don't have the tools yet, to have the courage to learn the language. But I will say that they don't feel the support.

Maria:

I would add that my drive for this work is reaching a point when Latinos stop being an afterthought. I'll be happy when we stop being an afterthought. Latinos need to stop being an afterthought. We need to be included from the beginning and not ignored. And I think that that is the biggest thing. Can we just stop ignoring that there're Brown people, and we're not going anywhere? And we're growing. I know we have a lot of Black/white issues, especially in the

Southeast, especially in a state like South Carolina. But now we also have this population that is very much a part of the threads that make the state's blanket, of who we are. And so anything that encourages folks to look at, see, and acknowledge the Brown people, is what we need.

Carrie:

I'm going to just assume that you guys recommend this model of what you're doing. How can others replicate it?

Maria:

Our PASOs Health Connections was actually designated by AMCHP [the Association of Maternal & Child Health Programs], which is a national organization, as a best practice in 2019. And our CCD program, Connections for Child Development Program, was designated a promising practice in the same year. We're hopeful to resubmit it soon and to be awarded a best practice designation. Not only is our PASOs Health Connections a best practice model but we've proven time and again, since probably 2009, when we started replicating, that you can replicate this model anywhere.

Carrie:

Is there anything in particular you think folks should know if they think about trying to do this program somewhere else? What would you recommend to an organization? Or maybe a really inspired person who wants to create something? What do they need to know?

Maria:

They need to let the people that you're trying to reach be the voice of, or a part of the voices, for the solutions. Let the people that you're trying to serve tell you what they need. If you're a person that has more social capital, you're more in the place of power, share that power by leveraging and bringing to the table the people that you're trying to serve. It's really easy, in that way. But it isn't always done that way.

Carrie:

Agner, do you have any thoughts about replication?

Agner:

Part of being a coordinator of CHW and program coordinator is belonging to or being part of other coalitions and alliances. Right now, we're participating with the CDC Foundation in the grant, they have grantees around the country. PASOs, we are a unique organization, but I have seen most of the similar organizations in the West Coast. The work they do, some of them just do the education process or do the connection process, but we do everything. So we are a unique organization. I have seen the CHW model in the West Coast, most of the West Coast, and they also have success connecting people and helping the families thrive in those states. But here in the East Coast, I think we are unique. We need to expand or have more organizations like us to support our families to thrive in the United States. Definitely.

Maria:

Part of that success for us, and what I encourage to folks that are interested in a similar model, is that we are very committed to community leadership development. You can see it, and you are witness to it through Agner. We are in the community, we're from the community, and we bring folks up from the community, lifting all of the community, essentially, to a higher opportunity for success, to have a voice, to really, truly become a part of the greater efforts, at least for South Carolina, to be a thriving state, and to be a healthier state overall.

Miriam:

Agner, you were saying you are unique on the East Coast, and I was curious if there's something specific about being in the South, for other organizations or people who are in Southern states thinking about replicating this. Are there any particular considerations you think are important for Latino communities in the South that people should keep in mind and consider?

Agner:

I think the overall history and the cultural mindset of the South, it means different things than other parts of the country. So definitely, that's something that you have to consider when supporting families. It's a long process, we still have work to do. Just because those two things, the history of the South and the general mindset of the South, the conservativeness, I guess, is the best way to describe it.

Maria:

Our state is conservative, and we do face a lot of discrimination and racism. So the work is not easy. We are a relationship-based organization. And so it's really connecting with people through understanding the human sciences of best practices and engagement with building strong relationships, and then leveraging those relationships to hold ourselves, but others also, accountable for the greater well-being of everyone. And that's a lot. That's a big encompassing idea. But I think one day at a time, as we live through the experiences, is finding ways to better communicate. It's having a greater understanding of ourselves and who we are and what our values are, so that we can be more accepting of others and where they sit and what their values are, and then finding ways of common ground where we can make small changes that then get us to where we want to be or want to do together.

Carrie:

One last question. I want to think in terms of possibility, even if it's not possible today. In terms of possibility, what could government systems — state, local, even federal governments — what could they do to better support your work and the families that you work with?

Maria:

I think that it would be great if they could set time to learn what community health work looks like through community health workers, and collect stories, see stories of success and how it makes a big difference and change when someone has a go-to community health worker that can help them resolve and find the answers. Some things are really difficult, but some things are really

simple in terms of the challenges that families and individuals face. And that one connection can open up and then change someone's entire life.

You know, I think of Agner's story. He came here and he and his wife didn't know how to navigate what was available here for them. Now he's working with the CDC! And his son is thriving in school, and he has access to all the services that he needs to help him develop as a child into adulthood. His wife is a teacher in one of the school districts here, and they give back everything that they have received. Agner helps me manage grants, like the one we talked about, and he's thriving and growing. And it's just fulfilling their lives, not just professionally, but personally. So if government can really see the impact of community health workers and what they can do, and how we can help people not feel alone, even within their own communities, feel like they're a part of something bigger, and that they can all work together — that's so powerful.

Agner:

I will add, and maybe it will sound like a cliché, but I don't believe that the importance and the impact of our Hispanic families has been recognized. I can't imagine if they decide to stop working in the farms, to stop working in the construction sites, to stop working the cleaning industry, I can't imagine a day without that. So I don't think and I don't feel that our government recognizes that impact or that importance, and the economic impact that our families cause in this state. Just imagine one day in a farm without farmworkers. Who will collect the strawberries, who will collect the apples? It's just that simple. That diversity is not recognized.

Policy Recommendations

The following policy recommendations include and build on those mentioned by Maria and Agner from PASOs.

To support the community health worker model:

- For organizations seeking to replicate the community health worker model, it is critical that they do needs assessment with the communities they seek to serve and let their communities dictate their needs and how services should be provided to them. Organizations should also seek to provide leadership development for participants and those who will serve as community health workers.
- Federal and state governments should support, through funding, organizations serving communities through models like the community health worker model. To ensure that organizations can access grants and funding opportunities, federal and state governments should:
 - Broadly share funding opportunity announcements and write them in plain language so organizations know they can apply
 - Seek out community-based organizations and directly invite them to apply for funding
 - Provide technical assistance and capacity building to community-based organizations seeking government grants
 - Allow smaller organizations to submit grant proposals in their best language
 - Add cultural competency, language capability, and close ties to communities as part of the criteria for funding opportunities

To improve and expand Latino and immigrant access to benefits:

- The federal government and states should, in partnership with impacted families and community organizations, work to identify and address barriers to social service programs. This includes building cultural competency and expanding language access and capabilities.
 - South Carolina should also expand Medicaid for adults and, when able, increase eligibility for the Children's Health Insurance Program (CHIP) to 300% of the Federal Poverty Level.
- The federal government should restore immigrant access to key federal benefits programs like Medicaid, CHIP, the Supplemental Nutrition Assistance Program, and housing subsidies:
 - The Department of Health and Human Services should allow recipients of DACA to seek health insurance on Affordable Care Act exchanges
 - Congress should pass the LIFT the BAR Act, which expands eligibility for federal benefits to all lawfully present immigrants in the United States
 - Congress should pass the HEAL for Immigrant Families Act, which expands eligibility for Medicaid and CHIP and allows people to get insurance coverage on Affordable Care Act exchanges regardless of their immigration status

1. To read Julie's research, see Julie Smithwick-Leone, *Looking at the Present and Towards the Future: The Perinatal Outlook for Latina Women and Children in the Midlands Region of South Carolina*, Division of Perinatal Systems of Palmetto Health Richland Hospital, 2005, <http://www.asph.sc.edu/cli/documents/PerinatalCare.pdf>.
2. Jacob Hofstetter and Margie McHugh, "South Carolina's Immigrant and U.S.-Born Parents of Young and Elementary-School-Age Children: Key Sociodemographic Characteristics," Migration Policy Institute, April 2021, https://www.migrationpolicy.org/sites/default/files/publications/mpi_nciip_parents-children-0-4-and-5-10-sc-2021_final.pdf.
3. "PASOs Connections for Child Development," PASOs, accessed April 27, 2022, <https://www.scpasos.org/pasos-connections-for-child-development/>.
4. Ibid, 2.
5. Ibid, 2.
6. Ibid, 2.
7. ASQ-3 is the third edition of the Ages & Stages Questionnaire, a developmental screening tool that pinpoints development progress in children between one month and 5-1/2. "ASQ-3," Ages & Stages Questionnaires, accessed April 28, 2022, <https://agesandstages.com/products-pricing/asq3/#:~:text=The%20Ages%20%26%20Stages%20Questionnaires%C2%AE,month%20to%205%20%C2%BD%20years>. The SE tool is the social-emotional screening tool that can be added to the regular development screening. "Social-Emotional Screening," Ages & Stages Questionnaires, accessed April 28, 2022, <https://agesandstages.com/about-asq/why-screening-matters/social-emotional-screening/>.
8. "2019 Snapshot: State of Hispanics in South Carolina," SC Commission for Minority Affairs, 2019, https://dc.statelibrary.sc.gov/bitstream/handle/10827/32121/CMA_State_of_Hispanics_SC_2019.pdf?sequence=1&isAllowed=y.
9. "Table 1: Income Eligibility Limits for Children's Health Coverage as a Percent of the Federal Poverty Level, January 2022," Kaiser Family Foundation, January 2022, <https://files.kff.org/attachment/Table-1-Medicaid-and-CHIP-Eligibility-and-Enrollment-Policies-as-of-January-2022.pdf>.
10. "Table 3: State Adoption of Options to Cover Immigrant Populations, January 2022," Kaiser Family Foundation, January 2022, <https://files.kff.org/attachment/Table-3-Medicaid-and-CHIP-Eligibility-and-Enrollment-Policies-as-of-January-2022.pdf>.
11. "Table 4: Medicaid Income Eligibility Limits for Adults as a Percentage of the Federal Poverty Level, January 2022," Kaiser Family Foundation, January 2022, <https://files.kff.org/attachment/Table-4-Medicaid-and-CHIP-Eligibility-and-Enrollment-Policies-as-of-January-2022.pdf>.
12. Tricia Brooks et al., "Medicaid and CHIP Eligibility and Enrollment Policies as of January 2022: Findings From a 50-State Survey," Kaiser Family Foundation, March 16, 2022, <https://www.kff.org/report-section/medicaid-and-chip-eligibility-and-enrollment-policies-as-of-january-2022-findings-from-a-50-state-survey-report/>.

An Urgent Response for Urgent Needs

Building and Sustaining a Children's Behavioral Health Crisis Continuum

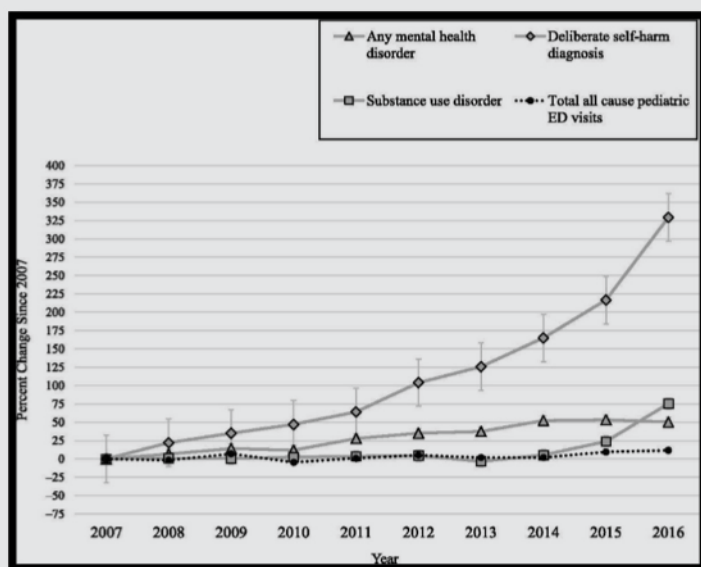
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From 2007 to 2016 (see *Table 1*), pediatric psychiatric emergency department (ED) visits for children ages 5–17 nationwide increased significantly: visits for deliberate self-harm increased 329%, visits for all mental health disorders rose 60%, and visits for children with a substance use disorder rose 159%.¹

Table 1. Pediatric emergency department visits



Source: C.B. Lo, J.A. Bridge, J. Shi, L. Ludwig, and R.M. Stanley, "Children's Mental Health Emergency Department Visits: 2007–2016," *Pediatrics* 145, no. 6 (June 2020): e20191536.

The COVID-19 pandemic has further exacerbated the child and youth mental health emergency.² The proportion of total ED visits for mental health conditions from 2018–2020 significantly increased from 4% to 5.7%.³ Such trends demonstrate the need for community-based services to meet the urgent needs of children, youth, and young adults who are experiencing a behavioral health crisis.

There are only about 8,300 practicing child and adolescent psychiatrists in the United States to meet the needs of approximately 15 million young people.⁴ Shortages of child and adolescent behavioral health providers lead to delays in screening, assessment, and treatment, which ultimately drive up the cost of care.⁵ While the behavioral health crisis is national, some states bear a more significant burden than others. Southwestern and Southeastern regions are particularly hampered by behavioral health provider shortages, the rural and frontier geography of their states, and a lack of widely available and affordable infrastructure such as public transportation and broadband or highspeed Internet access.

Disparities

Although the national rise in the proportion of ED visits for mental health is alarming on its own, some racial, ethnic, and historically underserved groups of children and youth are disproportionately burdened. The suicide rate for Black children and youth increased from 2.55 per 100,000 in 2007 to 4.82 per 100,000 in 2017.⁶ Black youth under age 13 are twice as likely to die by suicide; Black males ages 5–11 are more likely to die by suicide compared with their white peers.⁷ Suicide attempts among Black youth are rising faster than among any other racial or ethnic group.⁸ In addition, a recent study found that even when Black youth access care in the ED, they are more likely to be physically restrained: in a sample of over 551,000 visits of patients ages 0–16, physical restraints were used 532 times. According to this analysis, Black pediatric patients were 1.8 times more likely to receive a physical restraint than a white patient. Boys were more likely than girls to be restrained.⁹

Suicide rates among children and youth residing in Southwestern states are higher than the national average. From 2016–2018, the average suicide rate among youth ages 10–24 in Arizona, Colorado, Nevada, New Mexico, and Utah was 15.98 per 100,000 compared with the national average of 10.3; New Mexico's rate is 19.6, nearly twice the national average.¹⁰ American Indian (AI) communities within these states have strikingly higher suicide rates when compared with the United States as a whole: the Indian Health Service (IHS) *Trends in Indian Health Report*, which provides data on AIs and Alaska Natives residing in IHS service areas, identified suicide as the second leading cause of death for children and youth ages 5–24.¹¹

Pervasive inequities such as lack of access to high-quality, culturally sensitive mental health care; provider bias; and deficit-focused institutional practices harm children and families of color and deepen intergenerational and community trauma.¹² Investments in policies to address social determinants of health, such as the Supplemental Nutrition Assistance Program, lead paint remediation, and housing assistance have improved children's health. The creation of the Children's Health Insurance Program (CHIP) improved health care access for children, with "significant gains for African American and Hispanic children in terms of access to well-child, doctor, and dental visits. Despite these improvements, it is important to recognize that children raised in African American, Hispanic, and American Indian populations continue to face higher risks of parental unemployment and to reside in families with significantly lower household net wealth relative to white children in the United States, posing barriers to equal opportunities and services that optimize health and vocational outcomes."¹³

We see disparities by sexual orientation, gender identity, and gender expression as well: according to The Trevor Project's third annual National Survey on LGBTQ Youth Mental Health, over 40% of LGBTQ youth, including more than half of transgender and nonbinary youth, seriously considered attempting suicide in the past year. Among survey respondents, 12% of white youth attempted suicide compared to 31% of Native/Indigenous youth, 21% of Black youth, 21% of multiracial youth, 18% of Hispanic youth, and 12% Asian/Pacific Islander youth. Transgender and nonbinary youth attempt suicide less when respect is given to their pronouns and they are allowed to officially change their legal documents.¹⁴

Addressing the Needs of Children and Families

These data call attention to the urgency with which states and communities must begin or continue developing and implementing a comprehensive, customized crisis services continuum for children, youth, and their parents or caregivers and the importance of employing a public health approach to behavioral health.

Behavioral health needs are typically treated as an individual or familial issue, to be addressed solely on a one-to-one basis. We disagree and instead embrace crisis response services as a critical component of a public health approach that embodies some of the guiding principles of a population health framework, including prevention and intervention at the earliest moment, reaching broad and diverse audiences, employing a developmental approach with age-appropriate intervention, and “recogniz[ing] that inherent in every community is the wisdom to solve its own problems.”¹⁵ At its core, a public health approach “promotes intervention before individuals need clinical services...[and] shifts the goals of practitioners to behavioral wellness and not just the absence of psychopathology.”¹⁶ Such an approach would be a paradigm shift away from our current bureaucratic, gatekeeping system — which typically refuses to deliver or pay for services in the absence of a Diagnostic and Statistical Manual (DSM) diagnosis — and toward a humane system squarely focused on responding to child and communal need.

The Institute for Innovation and Implementation at the University of Maryland School of Social Work is currently engaged as an expert consultant with the Substance Abuse and Mental Health Services Administration (SAMHSA) to lead listening sessions with a diverse group of thought leaders, including clinicians, policymakers, state agencies, families, and young people, focused on the development of a crisis continuum customized to meet the needs of children, youth, young adults, and their caregivers. This work with SAMHSA builds upon our past efforts in hosting a series of five two-day mobile response and stabilization services (MRSS) peer academies with teams from 27 states and territories. Much of our work includes a focus on reducing reliance on residential care, increasing access to high-quality and effective home- and community-based services, and implementing sustainable financing strategies for MRSS, High Fidelity Wraparound, intermediate care coordination, and specific evidence-based practices. The Institute has also authored seminal documents on MRSS, including a 2018 paper, *Making the Case for a Comprehensive Children's Crisis Continuum of Care*, for the National Association of State Mental Health Program Directors.

We draw upon that experience, and our history of providing technical assistance to nearly every state and territory, in recommending that any continuum must be firmly rooted in system of care (SOC) values and principles.¹⁷ First developed to serve children and youth with serious emotional disorders and their caregivers, SOC's have since expanded into a concept that may be applied to any population receiving services and supports from multiple agencies or providers.¹⁸ SOC's operate under certain principles and practices to facilitate collaboration among various agencies.

System of Care Values

- **Family/caregiver- and youth-driven:** As evidenced by self-determination in services, with support for young people to participate based on age and development, and ongoing, measurable involvement in the planning, development, implementation, and evaluation of system-level policymaking.
- **Home- and community-based:** Services and supports provided in the home, school, primary care, or other noninstitutional settings.
- **Equitable:** Services and supports designed, implemented, and evaluated in collaboration with children, youth, and families in a manner designed to eliminate disparities in accessibility, availability, quality, and short- and long-term outcomes.
- **Culturally humble and linguistically competent:** Services and supports adapted to reflect the cultural, racial, ethnic, and linguistic needs and preferences of children, youth, and their caregivers to ensure accessibility regardless of religion, national origin, gender, gender expression, sexual orientation, physical disability, socioeconomic status, geography, immigration status, or other characteristics.
- **Strengths-based and individualized:** Services and supports focused on the positive attributes or characteristics of each child, youth, and caregiver and tailored to their unique preferences and needs.
- **Data-driven and outcome-oriented:** Mechanisms to ensure that supports, services, providers, and systems are focused on continuous quality improvement and have adopted — in collaboration with children, youth, and families — procedures, policies, and practices to track, manage, and analyze metrics in support of short- and long-term outcomes.
- **Trauma-informed:** Services and supports that shift the focus from “What’s wrong with you?” to “What happened to you?” by realizing the widespread effects of trauma — physically and/or emotionally harmful events that adversely impact well-being — on children, youth, and caregivers; integrating knowledge about trauma into policies, procedures, and practices; and actively avoiding retraumatization.¹⁹

A Children's Crisis Continuum

Asking for Help: Crisis Call Lines

The current 911 system was developed following President Johnson's Commission on Law Enforcement and Administration of Justice in 1967.²⁰ Although 911 is available 24/7, call takers and dispatchers have typically not received training on how to respond to those in behavioral health crisis.²¹ In addition, a 911-directed response has typically included law enforcement. As with 911 call takers, law enforcement typically has limited training and as such has transported children and youth to emergency departments or jail.

To redirect such calls away from law enforcement and toward specialized responders, Congress recently enacted laws²² to establish 988, a three-digit number analogous to 911 designed to assist individuals in crisis. Like 911, 988 will operate 24/7 and is scheduled to begin operation in July 2022. However, the *what* and *how* of implementation have been left to states with only limited technical

assistance, training, and funding from federal agencies. Nonetheless, by June 1, 2022, 16 states (Colorado, Connecticut, Illinois, Indiana, Kansas, Maryland, Michigan, Mississippi, Nebraska, Nevada, New York, Oregon, Utah, Virginia, Washington, and West Virginia) had enacted specific legislation to begin implementing 988. Of those, four (Connecticut, Nevada, Oregon, and Washington) had one or more child- or youth-specific implementation planning provisions included in the enacted legislation.²³

In implementing 988, states must be mindful of the unique needs of children and families. We believe that a crisis should be **defined by the caller** rather than by an external entity or call taker. What constitutes a crisis for one family or caregiver may not for another; it is important to use the family or caregiver's own definition, based on their own needs and strengths. Engaging families and caregivers in a culturally humble, linguistically competent manner is essential, not just to resolve the current crisis but also to begin to develop the trust necessary for ongoing stabilization.

Creating a single point of access, as is intended with 988, can streamline access to timely, necessary services and supports for children, youth, and families experiencing a mental health crisis. A single phone number available to the community and child-serving partners (e.g., child welfare, juvenile justice, schools, pediatricians, etc.) to call with a “no wrong door” approach simplifies what has historically been a time-consuming, complex, and sometimes dispiriting process.²⁴ The call line or center should be staffed by clinical and paraprofessional staff, including licensed behavioral health professionals with appropriate child and family expertise and experience. These staff will briefly screen callers and then dispatch a mobile response team.

Mobile Response Services

Rather than rely on traditional response models of police contact or ED admission or on attempts to modify the adult crisis response model (which tends to focus on transporting the individuals to a crisis receiving center), we believe the best model to meet the urgent behavioral health needs of children, youth, and their families is MRSS.

MRSS is a child-specific, youth-specific, and family-specific crisis intervention model for home- and community-based response and stabilization services within a children's crisis continuum. MRSS is designed to meet a caregiver's sense of urgency when children and youth begin to demonstrate behavioral changes associated with the early phase of a crisis, commonly understood as pre-crisis.²⁵ MRSS also prevents contact with law enforcement during a crisis, which avoids exacerbating the distress that young people — particularly Black, Indigenous, and young people of color and their families, and those in low-income, segregated communities²⁶ — report when interacting with law enforcement.

MRSS provides immediate assistance to youth and caregivers in de-escalating symptoms and behaviors; assisting youth and caregivers with identified supports, resources, and services in their community to minimize risk, aid in stabilization, and improve life outcomes; resolving the crisis; identifying potential triggers of future crises; and developing and implementing strategies to effectively de-escalate potential future crises and avert and divert from restrictive levels of care (ED, residential treatment, etc.), out-home-placement, and unnecessary contact with law enforcement and juvenile justice.²⁷

A key distinction between crisis services for children and youth versus adults is that families and caregivers are often involved in facilitating a young person's care. For this reason, systems that serve youth, especially youth under the age of 18, must plan for family and caregiver engagement — not just involvement — from the outset: that is, motivating and empowering families to recognize their own needs, strengths, and resources to support their active role in individualized service planning and delivery. For transition age youth 18 and older (and some younger youth, based on state law),²⁸ parental consent is not required for intervention and treatment, but some may elect to involve their family or other natural supports in developing their plan of care. MRSS interventions are often strengths-based and focused on coordinating resources, including natural supports, to keep the person in crisis at the least restrictive level of care.

In a child centric MRSS model the ethos is “always respond.” MRSS is dispatched upon request, which allows the mobile response team to intervene and de-escalate at the earliest opportunity consistent with a public health approach, which reduces the need for high levels of care and/or police involvement that may increase the risk for referral to child welfare or juvenile justice. Avoidance of police involvement is especially critical for children and youth of color who are more likely to face harsh consequences, from school exclusion^{29,30} to arrest,³¹ than their white peers.

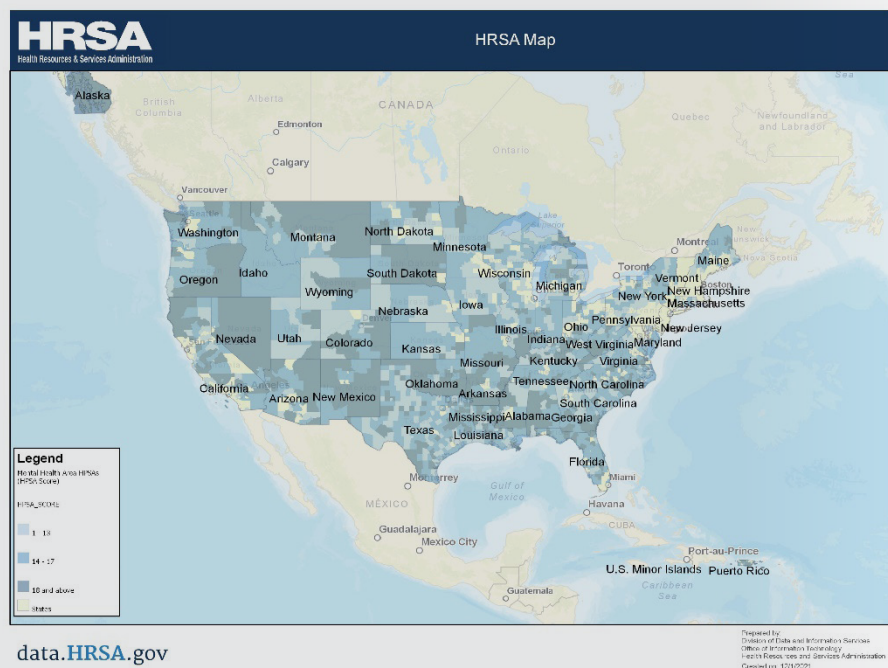
Does MRSS Work?

Empirical and peer-reviewed literature from early adopter states and localities suggests that mobile response services are successful in diverting children and youth from EDs, inpatient treatment, and out-of-home placement and in achieving cost savings:

- **Connecticut:** The Child Health and Development Institute published an evaluation in 2018 that found that children and youth who received MRSS had a 16% to 34% reduction in risk for any subsequent ED visit in an 18-month follow-up period.^{32,33} An earlier evaluation of the state's Emergency Mobile Psychiatric Services (EMPS) found that the 2014 average cost of an inpatient stay for Medicaid-enrolled children and youth was \$13,320, while the cost of MRSS was \$1,000, a net savings of \$12,320 per person. In Fiscal Year 2013, EDs referred to EMPS 1,121 times, and 553 referrals were coded as “inpatient diversions.” Of the 553 referrals, approximately 60% (or 332) were Medicaid-enrolled for a cost savings of over \$4 million.³⁴ Apart from cost savings, 40% of parents/caregivers reported improvement in their child's symptoms following MRSS services, as measured by the Ohio Scales, and 88% of parents/caregivers reported being extremely or moderately satisfied with the services provided.³⁵
- **Milwaukee, Wisconsin:** Wraparound Milwaukee serves all Milwaukee County youth with serious emotional and mental health needs and is the single payer of care. In 2018, 1,192 or 84% of children and families enrolled used crisis stabilization services at an average cost of \$481.47 per child, per month — far less than the \$786 per day paid for psychiatric hospitalization.^{36,37}
- **New Jersey:** Since its inception in 2004, MRSS maintained 94% of children in their current situation, including children involved in the child welfare system. From 2014–2018, between 95% and 98% of all children have remained in their current living situation, thereby avoiding costs associated with inpatient or residential treatment and juvenile justice interventions. However, as Casey Family Programs noted, “it is difficult to attribute the effect to any particular intervention” given New Jersey's commitment to developing and implementing a robust array of services for children and their families.³⁸

MRSS must exist with a continuum of care. Although services may be initiated during a crisis, a comprehensive array of interventions is necessary to maintain stabilization through engagement in cultural and linguistically competent clinical intervention as well as natural and community supports.

Opportunities and Challenges for States



As with other states, communities in the Southeastern and Southwestern regions face both opportunities and challenges in implementing MRSS. Rural and frontier communities in these states face poorer access to behavioral health services: while roughly two-thirds of all U.S. counties had at least one mental health facility serving youth, fewer than one-third of all highly rural counties had such a facility.³⁹ Health professional shortages are present in every state but are particularly acute in the rural Southwest and some areas of the South and Southeast.

As these states and communities consider how to develop and implement crisis services to children, youth, and caregivers, we encourage them to explore innovative solutions such as leveraging entitlement funds and shared savings models that enhance sustainability, increasing Medicaid reimbursement rates for behavioral health providers,⁴⁰ establishing or growing the use of trained family and youth peers and community health workers, and engaging and collaborating with community institutions and partners.

Financing and Sustaining Services

When planning, developing, and implementing a children's crisis continuum, states and communities should build with long-term sustainability in mind. Jurisdictions that have adopted a whole-population approach, which provides care for children regardless of payer source or agency involvement, have realized the most success in reducing an overreliance on these acute care and restrictive settings and in reducing child welfare and juvenile services caseloads.^{41,42} However, in such states, the agency that oversees and operates crisis services may not be the direct beneficiary of that success.⁴³ Instead, savings accrue to other child-serving agencies such as child welfare, juvenile justice, school systems, or emergency medical services. In addition, benefits from the provision of crisis services may “accrue many years or decades into the future or are not traceable to any one individual.”⁴⁴

This challenge has been termed the “wrong pockets” problem, and it arises when one agency makes an investment or bears the cost of operating a program that will generate immediate or long-term benefits to an entirely different agency. “In other words, money comes out of one ‘pocket’ (i.e., agency or budget area) and goes into a separate ‘pocket.’”⁴⁵

Solving this “wrong pockets” problem typically requires incenting or mandating cross-agency collaboration in a shared savings model. States and communities must, at the fore, give sufficient attention to recapturing and reinvesting savings garnered by averting or diverting from acute and residential care, child welfare, and juvenile justice to community-based crisis services like MRSS to promote sustainability.⁴⁶ State governance bodies must consider how siloed agency budgets (or “pockets”) could be aligned or pooled via an interagency body (e.g., a care management entity⁴⁷ or children's cabinet)⁴⁸ to use resources flexibly across sectors.⁴⁹

Funding sources that could be aligned or pooled include Medicaid, local and state educational funds, child welfare/IV-E dollars, mental-health state general funds, hospital community-benefit dollars, and/or federal block grants, including those from SAMHSA, the Health Resources and Services Administration, and the Department of Justice's Bureau of Justice Assistance. These funding streams could be blended or braided⁵⁰ to support the provision of MRSS to all eligible populations, rather than limiting it to those served by a particular agency or eligible for a particular program such as Medicaid.

Best practices for sustaining MRSS combine multiple funding streams to ensure flexibility and sustainability across populations. Such flexibility is especially important in states — which are heavily concentrated in the Southeast⁵¹ — that have not elected to expand Medicaid eligibility as permitted under the Patient Protection and Affordable Care Act. States that have combined several revenue streams to support and sustain the provision of MRSS include Connecticut, Georgia, New Jersey, and Oklahoma.

In addition, states could consider expanding their mental health parity laws to mandate commercial insurers provide reimbursement for crisis services, including MRSS. Although the Employee Retirement Security Act of 1974 (ERISA) preempts states from imposing mandates on self-insured employer health plans, states are free to mandate coverage for state-regulated insurers. Massachusetts, for example, requires all state-regulated insurers to provide coverage for mobile crisis and crisis stabilization services.⁵²

The American Rescue Plan Act (ARPA)⁵³ provided additional funding to states for crisis services via the Mental Health Block Grant (MHBG).⁵⁴ MHBG funds can assist states (and their localities) in covering planning, design, implementation, information technology enhancements, and quality monitoring activities that are generally not reimbursable under Medicaid. In addition, Section 9813 of ARPA provided an enhanced match to states for “community-based mobile crisis intervention services.” The section permits states to claim an 85% match for such services for 12 fiscal quarters beginning April 1, 2022, through March 31, 2027. The National Association of State Mental Health Program Directors published a technical assistance brief, *Funding Opportunities for Expanding Crisis Stabilization Systems and Services*, that covers the intricacies of federal financing in detail; it is an exceptional resource for states.⁵⁵

Braided funding involves coordination of two or more funding sources to support the total cost of a service. A single entity or coordinated agency oversees all expenditures; however, each funding stream remains separate to allow for the careful accounting of how every dollar from each budget line is spent and to avoid duplication of services. Most funding streams — be it state, federal, or grant dollars — require careful tracking of staff time, with requirements for allocation of personnel hours and other revenue-specific accounting and allocation requirements. Consequently, when multiple funding streams are paying for a single program or system, the system needs to be carefully designed and monitored to ensure compliance with all applicable federal and state statutes and regulations.

Blended (or pooled) funding combines revenue from multiple funding streams into one “pot” to maximize flexibility. However, individual funding streams or awards lose their award-specific identity. Blending funds can maximize flexibility across populations, but can also be administratively challenging, as funders must accept reports on services provided across the total population served, rather than services provided via a specific revenue stream. In addition, some federal and state statutes may prohibit the blending of some funds.⁵⁶

Family and Youth Peer Support

Engaging community partners and paraprofessionals such as peer support early in the process of developing MRSS is critical in building a model that aligns with the cultural and linguistic needs of families it is likely to serve. Apart from immediate crisis response, MRSS teams often partner with or provide education and training for emergency responders, including police and emergency medical responders, residential treatment providers, school personnel, and local child welfare and juvenile justice agencies.

In late 2021, the Center for Medicaid and CHIP Services, in a state health official letter designed to provide guidance on the scope of and payments for community-based mobile crisis services, reinforced the use of peers in crisis services: “best practices include incorporating trained peers who have lived experience in recovery from mental illness and/or SUD [substance use disorder] and formal training within the mobile crisis team; responding without law enforcement accompaniment, unless special circumstances warrant inclusion, in order to support justice system diversion.”⁵⁷

Family peer support providers “deliver peer support through face-to-face support groups, phone calls, or individual meetings. They bring expertise based on their own experience parenting children or youth with social, emotional, behavioral, or substance use challenges, as well as specialized training, to support other parents and caregivers.”⁵⁸ Youth peer support providers

connect “youth and young adults with mental health conditions or substance use disorders with young adults who have experienced similar challenges and completed specialized training to learn how to use their experience to support others. Like adult peer support, [youth peer support] encompasses a range of activities and interactions focused on promoting connection, inspiring hope, and supporting young people with mental or substance use disorders to set their own goals and take steps toward building fulfilling, self-determined lives for themselves.”⁵⁹

Over 30 states⁶⁰ cover the provision of family and/or youth peer support as a Medicaid-reimbursable service. In addition, several states encourage or permit the use of peers as part of MRSS or other crisis services including:

- **Kentucky**⁶¹ requires certified peers, including youth, as part of its residential crisis stabilization programs.
- **Georgia**⁶² requires each mobile crisis team to respond with two staff. One of the two must be a licensed provider (e.g., licensed clinical professional counselor, licensed clinical social worker, or licensed marriage and family therapist), but the other may be a certified peer specialist.
- **Virginia**⁶³ permits the inclusion of peer support specialists as part of the mobile crisis services, including the use of family support partners by caregivers when the services is provided to a child or youth under 21.

We believe Youth Peer Support (YPS) is an essential component within the children's crisis continuum of care. YPS connects youth and young adults with behavioral health conditions with young adults who have experienced similar challenges and completed specialized training to learn how to use their experience to support others. Like adult and family peer support, YPS encompasses a range of activities and interactions focused on promoting connection, inspiring hope, and supporting youth toward wellness and recovery.⁶⁴ YPS may also be helpful as young people navigate the transition between often disconnected child and adult-serving behavioral health systems.⁶⁵

Community Collaboration and Harnessing Community Resources

Apart from direct service provision, the provision of MRSS must be well coordinated with other child-serving system partners and community partners. When a child experiences a behavioral health crisis, the family is apt to engage with multiple child-serving entities (e.g., pediatricians, schools, child welfare, law enforcement, etc.). These system partners must work together to maximize the availability and accessibility of services — particularly when fiscal resources and human capital are scarce — and to minimize retraumatization and unnecessary duplication of assessments, plans of care, and direct services.

We encourage communities to build from strength. We appreciate that all too often, communities — especially historically disadvantaged communities — in the Southwestern and Southeastern United States have been viewed as deficient “complex masses of needs and problems.”⁶⁶ Rather than focusing on what resources these communities lack, we recommend identifying your “diverse and potent webs of gifts and assets.”⁶⁷ You might begin with a needs assessment that includes a map of local or regional resources such as physical infrastructure, community-based and provider organizations, associations (e.g., YMCA or YWCA, civic or social clubs, faith-based organizations, etc.),

and institutions (e.g., libraries, hospitals, schools, etc.). The connection between these resources is the social capital upon which communities can begin to plan, develop, and implement crisis services that produce the outcomes deemed most critical by their children, youth, and families.

Using assets identified in the resource mapping, communities may wish to begin by strengthening existing programs or slowly expanding upon them. This could include attention to staff development, training and coaching, and supervision; the purchase, upgrade, or repair of hardware or software; or creating formal partnerships. Programs that coordinate city, county, or regional resources with home- and community-based service providers realize significantly more success, particularly if they reduce or eliminate information silos to share data across child-serving agencies to target scarce resources most effectively and efficiently.

States should encourage the use of peer learning networks or quality collaboratives among communities as well, to share technical assistance and successful strategies for developing and sustaining prevention and stabilization services. Local communities are acutely aware of the individual, familial, economic, and social costs associated with mental health crisis. The federal government is responding with funding, but funding alone is insufficient. We also need an investment in program evaluation and research to understand which practices are most effective. From this evidentiary base we can focus on disseminating these successful programs and the customizations necessary to empower children and families in every community.

A Call for Action: Testing New Models of Care

While myriad financing options exist for states, the complexity and administrative burden of developing, implementing, and scaling culturally and linguistically competent crisis services while complying with a federal mandate to begin 988 operations is likely to overwhelm the operational capacity of many state agencies. There is a danger that 988 call volume will quickly exceed a state's ability to answer and respond, to say nothing of the fiscal and human capital demands associated with hiring, training, data collection and analysis, and quality improvement activities. Workforce shortages existed prior to the COVID-19 pandemic but have been exacerbated by it with significant number of providers reporting elevated symptoms of burnout, depression, and trauma that can negatively impact quality of care and precede career change.⁶⁸

To assist states in navigating these complexities, we call upon the U.S. Department of Health and Human Services (HHS) to create a federal demonstration project to assist states while broadening and deepening the research base for crisis services, motivate potential adopters, encourage the diffusion of promising models, and test innovations, including two-generation approaches that intentionally provide services for both children and their families.

Federal demonstration projects waive existing law and regulations to propose and test new models of care delivery. These projects usually provide federal matching funds over a specified period of time (typically three to seven years) for states and communities to test whether innovative programs can support higher quality care and improve outcomes at equal or lower total cost. Participation in federal demonstration projects is by competitive application.

In launching such a demonstration, HHS could focus its efforts on historically underserved communities or regions and build upon lessons learned in previous projects such as:

- Rural Integration Model for Parents and Children to Thrive (IMPACT), a two-generation, cross-agency initiative that “emphasized health, human service, and workforce development services for both parents and children in low-income families, with the ultimate goal of reducing child poverty” in 10 rural and tribal communities.⁶⁹ This demonstration was designed with offices and bureaus under HHS, as well the Department of Agriculture (USDA), Department of Labor (DoL), and the Department of Education (USDE), to guide and provide robust technical assistance.
- Performance Project for Disconnected Youth, which included interagency partnerships between HHS, DoL, USDE, DoJ, and Housing and Urban Development. The program waived federal statutory and regulatory requirements to assist grantees in blending and braiding funds to support disconnected youth (those neither in school nor working) ages 14–24.⁷⁰
- Integrated Care for Kids (InCK) Model to “improve child health, reduce avoidable inpatient stays and out-of-home placement, and create sustainable Alternative Payment Models (APMs)...The InCK Model supports states and local providers to conduct early identification and treatment of children with health-related needs across settings. Participants are required to integrate care coordination and case management across physical and behavioral health and other local service providers to provide child- and family-centered care.”⁷¹
- Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009 Quality Demonstration Grant Program made 10 awards to 18 states to “identify effective, replicable strategies for enhancing the quality of health care for children.”⁷² Awardees could use the funds to support efforts in five categories, including enhancing health information technology and developing or expanding provider-based care such as care management entities, school-based health centers, and patient-centered medical homes.

We call upon Congress to authorize a place-based federal demonstration that would enable states and localities to identify, plan, implement, refine, and evaluate two-generation crisis services that would provide service to the child and their family (parent/caregiver, siblings). A child's crisis affects the entire family. Early intervention in such crises, as with MRSS, provides an opportunity to build and reinforce coping and problem-solving skills of families, which promotes stabilization. If crisis services are delayed, or are focused solely on the child, families may not receive the services and supports necessary to de-escalate or to avoid or ameliorate future crises. As a result, these families may experience repeat breakdowns that have the potential to put them in contact with law enforcement, child welfare, and juvenile justice.

The proposed demonstration could include intensive, site-specific technical assistance for planning, developing logic models, and theories of change; needs assessments; and learning collaboratives. The demonstration could require in-kind or financial match from institutional or community partners.

We recommend that the demonstration embrace place-based principles, including attention to racial equity, promoting cross-agency collaboration, engaging community partners, and promoting a culture of learning.⁷³ We further recommend that the project permit the fullest, most flexible use of funds for infrastructure and administration as “a common refrain from place-based organizations implementing place-based programs is that they have not been provided enough funding for the operational or backbone support that enables long-term capacity building and

changemaking in a place.”⁷⁴ Permitting or encouraging the use of technology as a workforce extender would build upon the nascent or emerging evidence being produced across the United States, including Southwestern states:

- **Colorado** is using telepsychiatry in rural hospitals. One study based on a program at the Colorado Children's Hospital compared program outcomes for usual ambulance transportation for in-person psychiatric emergency versus telepsychiatry at geographically dispersed EDs. Compared with ambulance transportation, children who received telepsychiatry consultations had significantly shorter median ED lengths of stay and lower total patient charges. Providers and parents/caregivers reported high satisfaction with overall acceptability, effectiveness, and efficiency of telepsychiatry.⁷⁵
- **Nevada:** The Rural Mobile Crisis Response (RMCRT) team began taking calls in November 2016. By September 2017, the RMCRT had served 243 youth and families across rural Nevada; 86% of youth were successfully diverted from the hospital. Many of the schools, hospitals and juvenile detention centers in rural Nevada are now equipped with various technologies, including Project ECHO resources through the University of Nevada School of Medicine, VSee, Zoom, and Poly, allowing for more efficient response times during crisis calls.⁷⁶ The RMCRT also developed an agreement with the Nevada Rural Hospital partners wherein the EDs call the team and they connect with the youth and family via video or in person to reduce unnecessary inpatient care, which sometimes involves hours-long transit to Reno or Las Vegas.⁷⁷
- **New Mexico:** In 2020, during the COVID-19 pandemic, the state launched NMConnect, a smartphone app that provides 24-hour crisis and non-crisis support and access to behavioral health professionals via talk or text. The app is linked to the New Mexico Crisis Access Line and offers connections to peer support specialists and resource referrals to substance use, mental health, and other community resources.⁷⁸

Whatever form the demonstration takes, we recommend the sponsoring department or agency should commit to working with a federal partner such as the Agency for Healthcare Research and Quality or the Office of the Assistant Secretary for Planning and Evaluation to collect and analyze data to demonstrate the effectiveness of interventions among diverse populations in urban, rural, and frontier communities and their potential for scale. Any evaluation would ideally incorporate some community-based participatory research techniques and principles in selecting the study design, data collection plan, and dissemination of results.

An Urgent Response for Urgent Needs: Building and Sustaining a Children's Behavioral Health Crisis Continuum

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How America Can Cross the Finish Line and Finally Guarantee Health Care to All Children

Stan Dorn, UnidosUS

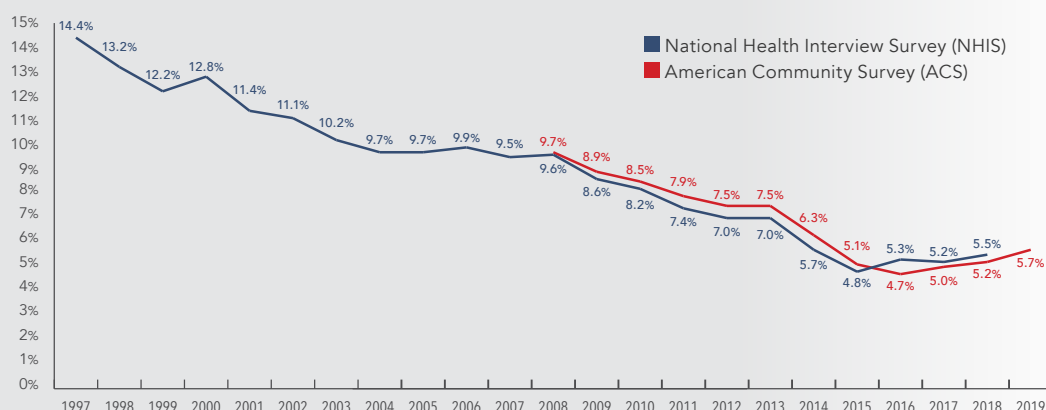
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Children's Health Coverage over Time: Glasses Full and Empty

A Long-Standing American Tradition of Bipartisan Progress on Children's Health Care

Increased health coverage for children since the enactment of the Children's Health Insurance Program (CHIP) in 1997 ranks among the leading accomplishments of American social policy. The percentage of children without any health coverage fell by more than two-thirds, plummeting from 14.4% in 1997 to between 4.7% and 4.8% in 2015 and 2016 before rising again to 5.7% in 2019 (*Figure 1*).

Figure 1. Percentage of children age 0–18 without any health insurance, by year and data source: 1997–2019



Source: Families USA analysis of National Health Interview Survey (NHIS) data, 1997–2018; American Community Survey (ACS) data, 2008–2019, accessed through IPUMS, University of Minnesota, www.ipums.org (IPUMS).

Note: NHIS = National Health Interview Survey; ACS = American Community Survey.

These extraordinary advances in children's health coverage reflected a strong, bipartisan commitment at federal and state levels as well as major philanthropic investments. Not only did CHIP's passage make millions of uninsured children newly eligible for health care but streamlined methods of enrollment and renewal increased participation rates in Medicaid and CHIP alike. In 1999, just 72% of Medicaid-eligible children and 45% of CHIP-eligible children were enrolled.¹ By 2008, fully 81.7% of all children eligible for either program were covered.² By 2013, on the eve of the Affordable Care Act (ACA) taking full effect, 88.7% of eligible children participated in Medicaid or CHIP. That proportion rose to 93.4% in 2016, falling slightly to 91.9% in 2019,³ but still remained far above past levels and more than in other state-administered public benefit programs.⁴

Remaining Gaps and Dangers

Millions of children benefited from these remarkable improvements, but our country has not yet ensured that every child in America has the health coverage he or she needs to grow up healthy and strong. Several challenges stand out as demanding action.

First, a troubling rise in the proportion of uninsured children from 2017 through 2019⁵ has rightly attracted considerable attention.⁶ Previous Families USA work⁷ identified three Trump administration policies as playing a central role in denying health coverage to eligible children:

- **Arbitrary, bureaucratic, red-tape requirements** that ended children's health coverage when their parents did not immediately respond to state paperwork demands
- **An unrelenting negative focus on immigrant communities** that led many parents to forgo health care and other essential services for their children, fearing that enrollment in public programs could thwart their families' paths to citizenship or ability to remain in the United States
- **Almost complete defunding of efforts to help eligible families enroll and to educate the public** about health care programs, despite evidence showing such efforts' importance and effectiveness

Second, more than 32 million children now covered by Medicaid⁸ will have their coverage placed at risk when current prohibitions against terminating Medicaid during the pandemic expire as a result of either state or federal action.⁹ Utah provided a grim preview of what might result. In 2020, when Utah redetermined eligibility for its CHIP program after receiving approval to take that step in the closing days of the Trump administration, more than 40% of all CHIP children were terminated. For 85% of the children losing coverage, the state ended health care based on the family's failure to respond to the state's request for information.¹⁰ If anything remotely comparable happens nationally when Medicaid terminations begin, children's coverage losses will exceed anything America has ever seen.

Third, two groups of uninsured children have remained beyond the reach of Medicaid and CHIP in good times and bad. One group consists of immigrant children born outside the United States whose parents lack authorization to live and work here. They represented 7.9% of uninsured children in 2019.¹¹ In most states, such children are ineligible for Medicaid, CHIP, and assistance buying private insurance in ACA marketplaces.¹²

The other group is made up of children who are eligible for Medicaid and CHIP but not enrolled. Both before and after the ACA's enactment, researchers found that such children comprised between 60% and 65% of all uninsured children.¹³ In 2019, researchers estimated that between 57.7% and 65.4% of all uninsured children qualified for Medicaid or CHIP.¹⁴ A long-standing challenge facing children's health advocates is figuring out how to reach what has thus far seemed to comprise an irreducible core of children eligible for help but not enrolled.

The Road Ahead: How Federal and State Policymakers Can Make Sure That All Children Get the Health Care They Need to Grow Up Healthy and Strong

America has been on a decades-long quest to guarantee health coverage to every child in our country. To finally cross the finish line on this long journey, three steps are essential:

- Preserving eligible children's Medicaid and CHIP coverage when the continuous coverage requirement in COVID relief legislation comes to an end
- Ending discrimination against immigrant children in defining eligibility for health care
- Automating eligible children's enrollment in Medicaid and CHIP as much as possible rather than keeping them uninsured until their families complete paperwork

A prior Families USA/First Focus paper addresses the first step.¹⁵ This paper discusses the latter two, in turn, after which it analyzes how these issues affect children in the Southeast and Southwest.

Ending Discrimination against Immigrants in Qualifying Children for Health Care

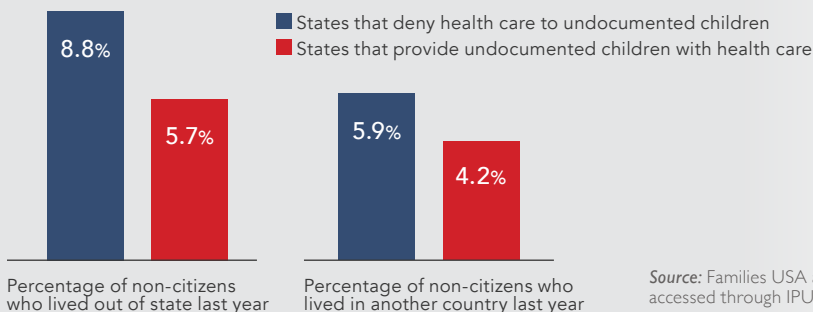
In California, the District of Columbia, Illinois, New York, Oregon, and Washington state, children qualify for Medicaid and CHIP programs regardless of immigration status.¹⁶ These states use their own resources to pay for coverage of immigrant children when federal funds are unavailable. For America to provide all of its children with health coverage, health care discrimination based on immigration status needs to end everywhere, not just in these six state-level jurisdictions.

Regardless of one's perspective on parents' decisions to come to the United States, it seems unfair to punish their children by denying them health care. Half of nonimmigrant children arrived in the United States by age 5, and two-thirds began living here by age 8.¹⁷ Many do not remember their countries of origin. Slightly more than half (52%) are age 12 or younger.¹⁸

This issue is a matter of health equity. Nearly nine in 10 immigrant children (86%) are children of color.¹⁹ To promote fairness in health and health care, policymakers need to end denials of children's health care based on immigration status.

Some may argue that if a state's child health program ends such discrimination, more immigrants will move to the state. That contention ignores research findings that immigrants choose where they live based primarily on employment prospects and immigrant networks already in place.²⁰ There is no evidence that the details of state benefit rules shape family decisions about where to set down roots. In fact, states that qualify undocumented children for health coverage experience less, not more, incoming migration from noncitizens. This is true both for relocation from anywhere outside the state (5.7% vs. 8.8%) and for moves from other countries (4.2% vs. 5.9%) (Figure 2). In relative terms, states that eliminate discrimination against undocumented children have 35% fewer immigrant families moving into the state from all locations combined and 30% fewer immigrant families moving in from other countries.

Figure 2. Incoming migration of noncitizens, by former location and state decisions to provide children's health coverage without discrimination based on immigration status: 2019



Source: Families USA analysis of 2019 ACS data, accessed through IPUMS.

Of course, these data do not show that immigrants are driven away by state decisions to qualify undocumented children for health care. Rather, they make the commonsense point that state public benefit rules do not play a major role in immigrant parents' choices about where to live, work, and raise their families.

Automating Eligible Children's Enrollment in Medicaid and CHIP Rather Than Keeping Them Uninsured Until Their Families Complete Paperwork

As noted earlier, between 60% and 65% of uninsured children qualify for Medicaid or CHIP — a state of affairs that precedes ACA's enactment. Federal and state officials have done extraordinary work streamlining enrollment, educating the public, and providing one-on-one assistance. Those steps have led to remarkably high participation rates compared to rates from the past and from many other programs.

But these measures, important though they are, leave intact the basic model of public benefit enrollment for people younger than 65. An uninsured child must remain without coverage until the family learns about available assistance, figures out whether the child is likely to qualify, completes application forms, and provides necessary documentation of eligibility. That works for many people, but it does not work for everyone — hence the seemingly irreducible core of children eligible for coverage who remain uninsured.

Benefit programs for seniors are structured very differently. They often include the following features:

- Eligibility rules and procedures make it possible for the government acting on its own to determine whether someone qualifies for benefits. Eligibility is defined in terms that can be verified based on data readily available to the agency administering the program.
- Enrollment is often automatic, with no action required from the affected individual. People can be enrolled in coverage and routed to a health plan that appears, from available data, well suited to meet their needs — unless they opt out. Action is needed to prevent coverage, not to obtain it.
- When premium payments are required, the government obtains them on its own without denying coverage until the individual takes action to make a payment.

Examples follow:

- Historically, seniors were automatically enrolled into Medicare Part B coverage of physician and outpatient care when they turned 65, with premiums deducted automatically from Social Security checks. Seniors could opt out of Part B, but very few did, while as one observer noted, “everyone eligible receives Part A no matter what.”²¹
- Eligibility for low-income subsidies (LIS) for Medicare Part D prescription drug coverage is generally based on prior-year tax income. However, if someone received Medicaid or Supplemental Security Income (SSI) in one calendar year, that person automatically qualifies for LIS the following year, without needing to submit an LIS application. That is true even in states where Medicaid eligibility is more generous than LIS eligibility. To make this system work, federal and state agencies exchange data, identify seniors who qualify for LIS based on past receipt of Medicaid or Supplemental Security Income, and automatically enroll them into LIS. If

they do not pick a Part D plan, one is selected for them. At annual open enrollment, if changed market conditions mean that their former plan costs them more than a different plan, they are transferred automatically into the lower-cost plan unless they opt out of the transfer.²²

- Premiums for Medicare Parts B and D vary based on income. However, income eligibility, and hence the amount of premiums due, is defined based on federal income tax records from two years in the past. If someone's circumstances have worsened since then, they can seek additional assistance. But if the person's income has risen, that does not increase premium costs until two years later.

Put simply, when it comes to seniors, but not children and families, health coverage is often the default when eligible people do not take action. The government assumes administrative burdens that programs serving people younger than 65 instead impose on families. When people younger than 65 fail to meet administrative responsibilities that could instead have been shouldered by government, eligible people can be denied essential health care. And the consequences of this burden shift are severe: children who are denied health insurance can suffer resulting harm for a lifetime.²³

The next section of the paper describes how health programs for children and families could be built more like programs for seniors, making coverage (rather than uninsurance) the default whenever possible. Health programs for families and children can and should be changed to use automatic methods for determining eligibility and enrolling families into coverage rather than denying health care until each family figures out the applicable program rules and takes action accordingly.

A Three-Step Process That Sets Up Family Health Programs for Enrollment Success

Step 1. Redefine eligibility so it can be established and verified based on available data

Health programs for children and families use eligibility definitions that can make it impossible for administering agencies, on their own, to identify people who qualify and then enroll them without the need for families to complete paperwork. For example, Medicaid eligibility is generally based on current monthly income. Many low-income families experience frequent short-term earnings fluctuations, often because employers change their hours at work in unpredictable ways. As a result, Medicaid eligibility, measured with precision, can be strikingly unstable.²⁴

States have the option to minimize this problem by providing children with 12 months of continuous eligibility. But even that approach creates questions at the point of enrollment, frequently requiring families to provide pay stubs and other income records to prove that their child qualifies based on current monthly income.

An alternative approach — used by federally funded college student aid, child tax credits during the pandemic's first several years, and determination of Medicare benefits described above — would guarantee minimum Medicaid eligibility based on prior-year tax data. If a family's income the prior year meets applicable Medicaid or CHIP standards, the family would automatically qualify during the current year. If income fell since the prior year, the family could qualify for additional assistance. But prior-year taxable income would guarantee Medicaid and CHIP coverage for numerous children and families, enabling their eligibility to be established without the completion of paperwork.

A similar approach could qualify families for advance premium tax credits (APTCs) on health insurance exchanges. Today, people apply for coverage before the calendar year begins or early during the year and estimate what their income is likely to be by the end of the calendar year. If they guess wrong, they may owe money when they file future tax returns. At that point, they must reconcile advance credits with their final annual income and household size. But before they enroll, they are asked to do the impossible and accurately predict their financial situation many months in advance.

Instead, minimum APTC's eligibility could be guaranteed based on prior-year income shown on federal income tax returns. As with Medicaid and CHIP eligibility, if a family's circumstances have worsened since the prior year, the family could obtain additional assistance by documenting their current circumstances. But such action by consumers would presumably be the exception, rather than the rule. Rather than waiting for the family to act before it qualifies for assistance, the administering agency could determine the family's eligibility and furnish assistance accordingly unless the family opts out.

This modernized approach to eligibility is supported by a range of experts from across the philosophical spectrum²⁵ — and it is not hard to see why. In addition to permitting greater participation by eligible families, this approach lowers administrative costs. For most people, eligibility could be established based on an exchange of electrons, without using taxpayer resources to finance the manual processing of application and verification paperwork.

Critically important, modernized eligibility rules would greatly improve program integrity. Today, it is impossible to know whether an APTC beneficiary is receiving the right amount of assistance; that fact will not become known until the current year is finished and a future tax return is filed. A greatly enhanced level of accountability will become possible under an approach that bases APTC eligibility on facts knowable from existing records rather than an inherently unknowable future state of affairs.

Medicaid and CHIP face program integrity challenges as well. Today, eligibility reviewers can ascertain nothing more than whether case records include documentation that proves compliance with all applicable procedural requirements. Reviews do not even attempt to estimate the percentage of beneficiaries who are in fact ineligible. In contrast, basing eligibility on facts knowable using prior-year income tax returns would let evaluators see whether children and families qualified for the assistance they received. And auditors could assess program integrity without wasting taxpayer dollars by incentivizing agency staff to spend precious time documenting each and every step they take with each and every applicant and beneficiary.

Put simply, redefining Medicaid and CHIP eligibility criteria so they can be satisfied based on available data simultaneously enables far more robust program participation, fewer burdens on hard-pressed families, much more efficient program operations, and enormous gains in program integrity.

Step 2. Use tax return filing or other wide intake methods to find uninsured children and families, including people who know little or nothing about health programs

The current basic model of health coverage for children and families relies on families' knowing that health benefits are available. In fact, a surprisingly large proportion of the eligible public is unaware that they may qualify for help.²⁶ Overcoming this structural problem requires an intake method that scoops up the eligible uninsured, whether or not they know the first thing about health programs.

Perhaps the most promising venue is income tax filing. In 2020, 92% of all uninsured people filed federal income tax returns or were claimed as dependents for earned income tax credits, including 86% of those with incomes below 150% of the federal poverty level (FPL).²⁷ In contrast, all health care providers combined saw just 50.8% of the uninsured in 2019.²⁸ One important reason to use income tax returns as a place to let the uninsured identify themselves and seek help is that, to paraphrase the saying attributed to bank robber Willie Sutton, "That's where the uninsured are." A second reason is that tax returns already contain much of the information needed to determine eligibility for health coverage. Put simply, tax returns are an efficient way for taxpayers to identify family members who are uninsured; authorize disclosure of relevant return data to the exchange or Medicaid program to see if uninsured family members qualify for free or low-cost insurance; and if they are eligible for free coverage, get them enrolled unless they opt out.

Step 3. Automate enrollment in specific health plans whenever possible

Tax returns could ask whether uninsured tax filers want to be enrolled in free health insurance if they qualify. Such free insurance would include Medicaid or CHIP. It would also include zero-net-premium exchange coverage. In fact, under current expanded eligibility for APTCs, nearly half of the uninsured (46%) are eligible for free health insurance through one of these programs,²⁹ as are more than 60% of uninsured children.³⁰

Policymakers pursuing this approach need a mechanism for plan selection when more than one zero-net-premium private plan is available and the family has not made a choice. One approach would focus on the subset of available plans that offers the most generous coverage, then randomize auto-assignment among those plans. That resembles an approach long used by Medicaid programs, where consumers are auto-assigned to a particular managed care organization if they fail to make a choice after a specified period of time.³¹

A more forward-leaning approach would make enrollment in zero-premium coverage the default unless the family opts out. In such cases, the family could be sent an insurance card, which could be activated by calling a number listed on the card or by using the card to seek health care.

Massachusetts achieved remarkable results from implementing forward-leaning default enrollment policies in that state's pre-ACA health coverage program.

- When people applied for coverage but did not select a plan, those who qualified for premium-free coverage were enrolled unless they opted out. That single policy increased total coverage gains by 35%–50% a year.³²
- Massachusetts also prevented families from losing coverage for nonpayment of premiums when they qualified for zero-premium plans. In such cases, families about to default on their insurance payments were transferred to zero-premium plans unless they opted out. That one policy preserved coverage for 14% of the applicable portion of the state's individual market, cutting in half the number of families who lost coverage for nonpayment of premiums.³³

Louisiana came as close as possible to a default-enrollment strategy in its initial implementation of Express Lane Eligibility (ELE), wherein children qualified for Medicaid based on SNAP receipt. Parents could opt out of data sharing between Medicaid and SNAP. Researchers described the initial results as follows:

“Only 1 percent of families whose children received SNAP but not Medicaid opted out of ELE. The remainder were sent Medicaid cards, which were automatically activated upon first use. Nearly 30,000 children received health coverage, further reducing the state’s already low percentage of uninsured children. After initial enrollment, 83 percent of ELE children used Medicaid to access care within a year — only slightly below the 88 percent of children who enrolled in Medicaid through other channels.”³⁴

Focus groups reported that families were delighted by this new and more automatic approach to enrollment.³⁵ Parents described it as “a gift from God” or “a blessing,” saying that they were “jumping for joy” when they received Medicaid cards for their children. It was clear that many would never have received coverage without such automated enrollment. One recently unemployed father, unfamiliar with Medicaid and CHIP, explained that health programs were completely “off my radar.” Others mistakenly thought their children would be ineligible or that their uninsured children were already covered. Parents described the auto-enrollment process as “basically common sense,” with families “automatically being enrolled, instead of second-guessing” themselves and wondering if they’re eligible. Even parents who had not yet used coverage to seek care for their children “valued the peace of mind that came from knowing their children were insured.”

Eventually, federal legal requirements for affirmative consent and information technology limitations forced Louisiana to change its approach. Instead of consenting to enrollment simply by using their children’s Medicaid cards to seek care, parents had to opt in by checking a box on the SNAP application form. Adding that apparently modest requirement reduced enrollment by 62%.³⁶ It is hard to imagine a clearer illustration of the need to change our country’s basic model of enrollment for children and families to make health care, rather than a denial of coverage, the default if eligible consumers fail to act.

This Approach Can Be Implemented at Either the Federal or the State Level

National reform. Federal implementation has the advantage that legislation can reform eligibility criteria to fit available data, as described above (see *Step 1* on page 140), making it easy to qualify for coverage and enroll automatically based on tax data. With minimum APTC eligibility guaranteed based on prior-year income, people could enroll in marketplace plans, knowing that premiums are fully covered by APTCs, without any danger of having to repay the IRS when filing their tax return at the end of the year if their income winds up exceeding their initial expectations. Sen. Van Hollen (D-MD) and Rep. Ami Bera, MD (D-CA) have introduced “The Easy Enrollment in Health Care Act” to implement precisely such reforms.³⁷

State-driven reform. Until federal legislation changes the ground rules to make health programs more family friendly, state lawmakers can nevertheless move forward. Maryland has already taken important steps in this direction, implementing an “Easy Enrollment” system that lets families who file state income tax returns identify uninsured family members and consent to sharing of their tax return data with the exchange to see if they qualify for free or low-cost health insurance.

Even though, at the initial stages of implementation, Maryland families have needed to initiate an application from scratch after checking the tax-consent box and receiving notice of likely eligibility, 9% of all uninsured who checked the box on their tax return enrolled in coverage in 2020, and 10% enrolled in 2021 — substantially more than the 1% take-up rate the IRS experienced in conducting a similar exercise during the Obama administration.³⁸ And even though only 11% of Maryland's uninsured are children younger than 18,³⁹ such children made up 28% of all Marylanders receiving coverage through Easy Enrollment in 2020 and 30% in 2021,⁴⁰ illustrating the potential power of a tax-based approach to reach and enroll uninsured children.

For states to realize the full potential of this new approach, without changes in federal law, they need to take several additional steps:

- In addition to giving tax filers an opportunity to identify uninsured family members and consent to disclosing tax information to the exchange or Medicaid to determine eligibility for free or reduced-cost insurance, tax returns could give tax filers a chance to request enrollment in zero-premium coverage if the uninsured family members qualify. That would enable automated enrollment in Medicaid, CHIP, and zero-net-premium exchange coverage. To reach even more eligible children and families, the return could inform tax filers that if they qualify for free insurance and do not select a health insurance plan for themselves, they will be enrolled automatically unless they opt out.⁴¹
- For zero-net-premium exchange coverage to be truly free, a state may need to hold families harmless against owing federal tax reconciliation payments if family income rises unexpectedly and APTC amounts claimed turn out to be more than are warranted, based on the final income tax return. A state could either create a mechanism for people to claim reimbursement or create a fully refundable state income tax credit to offset any federal tax reconciliation charges. Such an approach would greatly increase the feasibility of auto-retention strategies like those used in Massachusetts as well as default enrollment in zero-net-premium exchange coverage. Put simply, this would mean that apparently free private plans are in fact free.⁴²
- To qualify families for health programs under current law, the state will sometimes need to collect information that supplements tax return data. Some of that information can be obtained by using personal identification data on the tax return (e.g., Social Security number, date of birth, and first and last name of adults in the family) to match reliable third-party data sources. With other information, several approaches are possible:
 - Information could be collected on a supplemental form included as part of the tax return or a separate form from the exchange. Such information would include attestations that show current monthly income at Medicaid- or CHIP-qualifying levels, which a state could choose to verify based on information on the tax return.⁴³ To help establish APTC eligibility, the tax filer could be asked a few questions about the income they expect to receive by the end of the year, whether they anticipate changes in family size, and whether they are offered health insurance on the job. However, it would be important to make sure that no tax form asks about health status, citizenship, or immigration status, despite those questions' potential relevance to health program eligibility.⁴⁴
 - The federal government could grant waivers that let states enroll as many eligible people as possible based purely on information included in or derived from the tax return.

- The Medicaid agency could grant presumptive eligibility, based on prior-year income shown on state returns. Community groups or Medicaid managed care organizations would need to proactively complete the process of enrolling into ongoing coverage.
- Children can qualify for Medicaid and CHIP based on state income tax returns through Express Lane Eligibility.⁴⁵ Through 1115 waivers, states may be able to provide ELE to adults.
- As much as possible, families filing returns electronically — and more than 90% of taxpayers, including very-low-income families, file electronically⁴⁶ — should be able to obtain an eligibility determination and complete the enrollment process at the same time they file the return. Coverage losses result when enrollment cannot be completed in one sitting, as illustrated by Massachusetts' above-noted experience with numerous beneficiaries' failing to complete their enrollment in a zero-premium plan after completing their application and qualifying for assistance. If such "real-time enrollment" is not feasible, an exchange or Medicaid program should engage in proactive telephonic outreach to complete the enrollment process.

Easy Enrollment laws like Maryland's have passed in Colorado, Massachusetts, New Mexico, and Virginia, and Pennsylvania is implementing the policy administratively, based on existing law, without any need for statutory change.

Federal support for state experimentation. If Congress is unable to pass a nationwide statute that modernizes enrollment and eligibility for children and families, it could grant states increased authority to experiment with such policies. In addition to giving states flexibilities needed to effectively streamline and automate enrollment, the legislation could fund information technology investments and other administrative activities needed for effective implementation, along with support for independent evaluation.

How These Issues Affect Children in the Southeast and Southwest

Defining Geographic Regions

To assess these issues' impact on children in the Southeast and Southwest, this paper relies on the geographic classification used by the U.S. Commerce Department's Bureau of Economic Analysis:

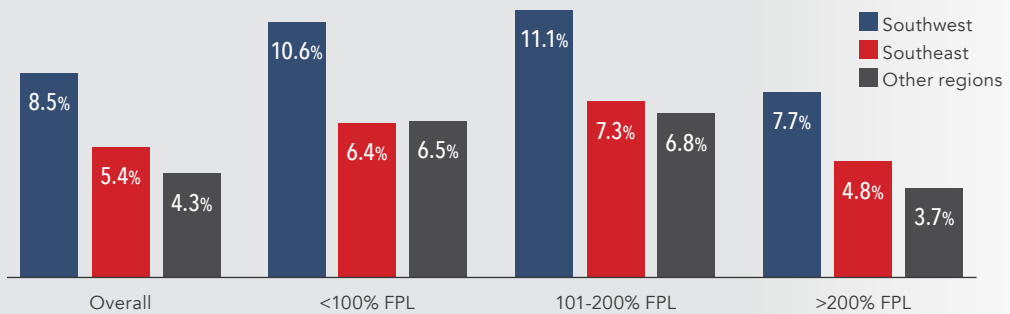
- Southwestern states are Arizona, New Mexico, Oklahoma, and Texas
- Southeastern states are Alabama, Arkansas, Florida, Georgia, Kentucky, Louisiana, Mississippi, North Carolina, South Carolina, Tennessee, Virginia, and West Virginia

The following analysis compares three groups of states: Southwestern, Southeastern, and states in other geographic regions combined. The estimates are for median states by region, rather than averages for all children within each region, to prevent a small number of large states from biasing the results. Overall, this analysis finds that the same challenges that face children across the country are present in these two regions as well, but with greater intensity — especially in the Southwest.

Uninsured Children Overall

Southwestern states have the highest percentage of uninsured children (8.5% in the median state), followed by Southeastern states (5.4%) and states in other regions (4.3%) (Figure 3). The same pattern holds true for children at every income level, except in families with incomes below 100% of the federal poverty level (FPL), where the percentage of uninsured children is slightly lower in the median Southeastern state (6.4%) than in all regions outside the Southwest and Southeast (6.5%).

Figure 3. Percentage of children without health insurance in the median state, by region and income as a percentage of the federal poverty level (FPL): 2019



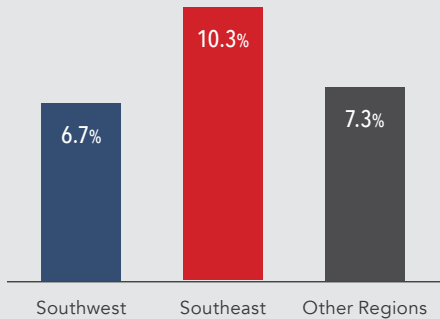
Source: Families USA analysis of Kaiser Family Foundation estimates of state health insurance status, based on 2019 American Community Survey data: "Health Insurance Status of Children 0–18," <https://www.kff.org/other/state-indicator/children-0-18/?dataView=1¤tTimeframe=0&sortModel=%7B%22colld%22:%22Location%22,%22sort%22:%22asc%22%7D>; "Health Insurance Coverage of Children 0–18 Living in Poverty (under 100% FPL)," <https://www.kff.org/other/state-indicator/poor-children/?dataView=1¤tTimeframe=0&sortModel=%7B%22colld%22:%22Location%22,%22sort%22:%22asc%22%7D>; "Health Insurance Coverage of Low Income Children 0–18 (under 200% FPL)," <https://www.kff.org/other/state-indicator/health-insurance-coverage-of-low-income-children-0-18-under-200-fpl/?currentTimeframe=0&sortModel=%7B%22colld%22:%22Location%22,%22sort%22:%22asc%22%7D>.

Note: Children are age 18 and younger. Southwestern states are Arizona, New Mexico, Oklahoma, and Texas. Southeastern states are Alabama, Arkansas, Florida, Georgia, Kentucky, Louisiana, Mississippi, North Carolina, South Carolina, Tennessee, Virginia, and West Virginia.

Undocumented Immigrant Children

States in all regions include many uninsured children who are ineligible for health programs like Medicaid and CHIP because of immigration status. The proportion of uninsured children who fall into this category is highest in the median Southeastern state (10.3%) and lowest in the median Southwestern state (6.7%) (Figure 4). In the median state outside these two regions, 7.3% of uninsured children are ineligible because of immigration status.

Figure 4. In the median state, percentage of uninsured children who are ineligible for health programs because of immigration status, by region: 2019

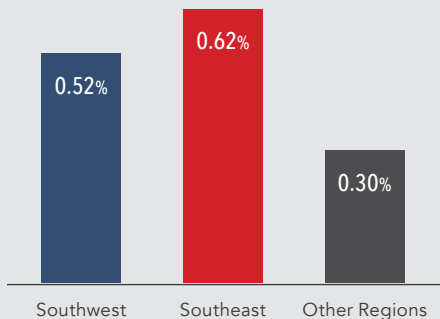


Source: Families USA analysis of 2019 American Community Survey data, accessed through IPUMS.

Note: Children are age 18 and younger. Southwestern states are Arizona, New Mexico, Oklahoma, and Texas. Southeastern states are Alabama, Arkansas, Florida, Georgia, Kentucky, Louisiana, Mississippi, North Carolina, South Carolina, Tennessee, Virginia, and West Virginia. Immigration status is imputed based on the results of Urban Institute microsimulations.

Those estimates, by themselves, are not sufficient to understand regional variation in undocumented children's health coverage. As noted earlier, children who lack health insurance for all reasons combined comprise a much higher proportion of all children in Southwestern states than in other regions. Figure 4 shows that undocumented immigrant children are a particularly small proportion of the uninsured in Southwestern states, but that is because such states have such a high proportion of total uninsured children, for all reasons combined. As a percentage of all children in the median state, undocumented uninsured are still most common in the Southeast (0.62%), but they are far more common in the Southwest (0.52%) than in states outside those two regions (0.30%) (Figure 5).

Figure 5. In the median state, percentage of all children who are uninsured and ineligible for health programs because of immigration status, by region: 2019

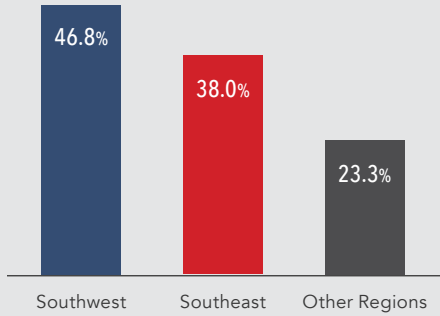


Source: Families USA analysis of 2019 American Community Survey data, accessed through IPUMS.

Note: Children are age 18 and younger. Southwestern states are Arizona, New Mexico, Oklahoma, and Texas. Southeastern states are Alabama, Arkansas, Florida, Georgia, Kentucky, Louisiana, Mississippi, North Carolina, South Carolina, Tennessee, Virginia, and West Virginia. Immigration status is imputed based on the results of Urban Institute microsimulations.

And among all undocumented immigrant children, the proportion who lack coverage is highest in the median Southwestern state (46.8%), lower in the median Southeastern state (38.0%), and lowest in the median state outside these two regions (23.3%) (Figure 6).

Figure 6. In the median state, percentage of undocumented children who are uninsured, by region: 2019



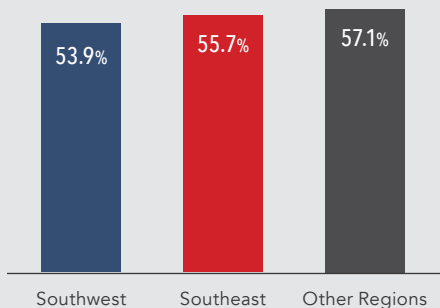
Source: Families USA analysis of 2019 American Community Survey data, accessed through IPUMS.

Note: Children are age 18 and younger. Southwestern states are Arizona, New Mexico, Oklahoma, and Texas. Southeastern states are Alabama, Arkansas, Florida, Georgia, Kentucky, Louisiana, Mississippi, North Carolina, South Carolina, Tennessee, Virginia, and West Virginia. Immigration status is imputed based on the results of Urban Institute microsimulations.

Uninsured Children Who Qualify for Medicaid and CHIP

Children who are eligible for Medicaid and CHIP comprise between 50% and 60% of uninsured children in all regions. However, those who qualify for these programs but are not enrolled make up a slightly lower proportion of all uninsured children in the median Southwestern state (54%) than in the median Southeastern state (56%) and the median state outside these two regions (57%) (Figure 7).

Figure 7. In the median state, percentage of uninsured children who qualify for Medicaid or CHIP, by region: 2019

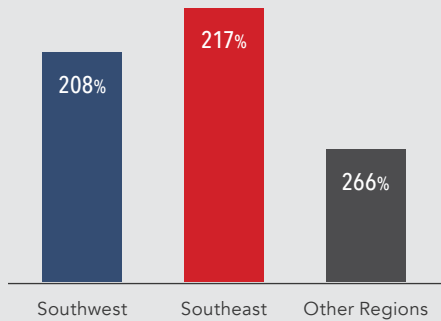


Source: Families USA analysis of 2019 American Community Survey data, accessed through IPUMS.

Note: Children are age 18 and younger. Southwestern states are Arizona, New Mexico, Oklahoma, and Texas. Southeastern states are Alabama, Arkansas, Florida, Georgia, Kentucky, Louisiana, Mississippi, North Carolina, South Carolina, Tennessee, Virginia, and West Virginia. Immigration status is imputed based on the results of Urban Institute microsimulations.

It does not follow, however, that Southwestern states are doing particularly well in reaching eligible uninsured children, followed by Southeastern states and then states in other regions. Eligibility is more limited in Southwestern and Southeastern states, which may make it easier to reach those who qualify. The median upper-income limit for Medicaid and CHIP is lowest in Southwestern states (208% of FPL), higher in Southeastern states (217%), and highest in other states (266%) (Figure 8).

Figure 8. In the median state, maximum income as a percentage of the federal poverty level for Medicaid or CHIP, by region: January 2022



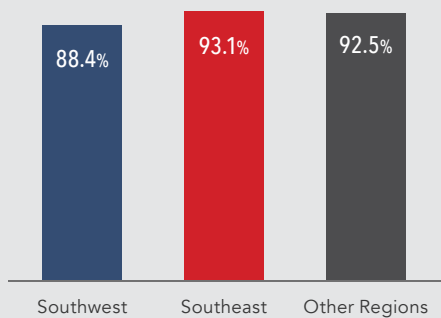
Source: Families USA analysis of Kaiser Family Foundation, "Medicaid and CHIP Income Eligibility Limits for Children as a Percent of the Federal Poverty Level" as of January 1, 2022,

<https://www.kff.org/health-reform/state-indicator/medicaid-and-chip-income-eligibility-limits-for-children-as-a-percent-of-the-federal-poverty-level/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>.

Note: Income levels are the maximum for Medicaid and CHIP eligibility of children age 18 and younger. Southwestern states are Arizona, New Mexico, Oklahoma, and Texas. Southeastern states are Alabama, Arkansas, Florida, Georgia, Kentucky, Louisiana, Mississippi, North Carolina, South Carolina, Tennessee, Virginia, and West Virginia. Immigration status is imputed based on the results of Urban Institute microsimulations.

In truth, Southeastern states have achieved the best results enrolling eligible children in coverage, reaching 93.1% of eligible children in the median state, compared to 92.5% in states outside the Southeast and Southwest and just 88.4% in Southwestern states (Figure 9).

Figure 9. In the median state, percentage of eligible children who were enrolled in Medicaid and CHIP: 2019



Source: Families USA analysis of Jennifer M. Haley et al., "Uninsurance Rose among Children and Parents in 2019,"

Urban Institute, July 2021, <https://www.urban.org/sites/default/files/publication/104547/uninsurance-rose-among-children-and-parents-in-2019.pdf>.

Note: Children are age 18 and younger. Southwestern states are Arizona, New Mexico, Oklahoma, and Texas. Southeastern states are Alabama, Arkansas, Florida, Georgia, Kentucky, Louisiana, Mississippi, North Carolina, South Carolina, Tennessee, Virginia, and West Virginia. Immigration status is imputed based on the results of Urban Institute microsimulations.

Conclusion

Children's health coverage is light-years ahead of where it was before CHIP's bipartisan enactment in 1997. But America has not yet reached the finish line of guaranteeing health care to every child.

To reach that line, child health advocates must overcome long-standing structural challenges. One challenge can and must be addressed by ending child health programs' discrimination based on immigration status, following the lead of trailblazing states.

The other long-standing challenge requires health programs serving children and families to shift their paradigm for program participation. Instead of denying health care until families tell the government what it already should know on its own, public agencies should, to the maximum extent possible, determine eligibility proactively and enroll families in coverage for which they qualify unless they opt out. America already uses this basic approach to provide many senior citizens with health care they are promised under federal law. America's children and families deserve no less.

1. Lisa Dubay et al., "Children's Participation in Medicaid and SCHIP: Early in the SCHIP Era," Urban Institute, March 1, 2002, <http://webarchive.urban.org/UploadedPDF/310430.pdf>.
2. Genevieve M. Kenney et al., "Medicaid/CHIP Participation Rates among Children: An Update," Urban Institute, September 19, 2013, <http://research.urban.org/uploadedpdf/412901-%20Medicaid-CHIP-Participation-Rates-Among-Children-An-Update.pdf>.
3. Jennifer M. Haley et al., "Uninsurance Rose among Children and Parents in 2019," Urban Institute, July 2021, <https://www.urban.org/sites/default/files/publication/104547/uninsurance-rose-among-children-and-parents-in-2019.pdf>. For year-to-year percentages from 2008 to 2014, see Genevieve M. Kenney et al., "Children's Coverage Climb Continues: Uninsurance and Medicaid/CHIP Eligibility and Participation Under the ACA," Urban Institute, May 10, 2016, <https://www.urban.org/sites/default/files/publication/80536/2000787-Childrens-Coverage-Climb-Continues-Uninsurance-and-Medicaid-CHIP-Eligibility-and-Participation-Under-the-ACA.pdf>.
4. For example, Quentin Palfrey, "Getting Public Benefits to the People Who Need Them," *Governing*, July 20, 2017, <https://www.governing.com/gov-institute/voices/col-improving-low-take-up-rates-benefit-programs-earned-income-tax-credit.html>; Mitchell Barnes et al. *The Social Insurance System in the U.S.: Policies to Protect Workers and Families*. The Hamilton Project, the Brookings Institution, June 2021. https://www.brookings.edu/wp-content/uploads/2021/06/Social-Insurance-FP_v4.5.pdf.
5. As noted earlier, American Community Survey (ACS) data showed a statistically significant increase in the number of uninsured children from 2017 to 2019. According to data from the Current Population Survey — Annual Social and Economic Supplement (CPS-ASEC), another such increase occurred from 2019 to 2020.
6. See, e.g., Joan Alker and Alexandra Corcoran, "Children's Uninsured Rate Rises by Largest Annual Jump in More Than a Decade," Georgetown University Health Policy Institute, Center for Children and Families (CCF), October 8, 2020, <https://ccf.georgetown.edu/2020/10/08/childrens-uninsured-rate-rises-by-largest-annual-jump-in-more-than-a-decade-2/>; Stan Dorn, et al., *America's Children Are Losing Health Insurance, Putting Their Futures at Risk: How National Lawmakers Can Help*. Families USA, September 2019, https://familiesusa.org/wp-content/uploads/2019/10/COV_Child-Health-Emergency_Report-Part-I-I.pdf.
7. Dorn et al., "America's Children Are Losing Health Insurance."
8. Center for Medicaid and CHIP Services, "July 2021 Medicaid and CHIP Enrollment Trends Snapshot," accessed May 3, 2022, <https://www.medicaid.gov/medicaid/national-medicaid-chip-program-information/downloads/july-2021-medicaid-chip-enrollment-trend-snapshot.pdf>.
9. As explained in more detail below, states are considering opting out of the coverage continuity requirement, forgoing the accompanying increased federal funding, and legislation passed by the House and pending in the Senate would end that requirement at a date certain, even if the public health emergency continues.
10. Katie Workman, "41% of Utah CHIP Recipients Lost Coverage in May due to Government Reversal," June 17, 2021, <https://www.ksl.com/article/50188678/41-of-utah-chip-recipients-lost-coverage-in-may-due-to-government-reversal>.
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41. Federal officials have been reluctant to enroll people in Medicaid without their affirmative consent. To overcome such reluctance, states could seek a waiver of applicable requirements or, as in Louisiana, have people consent to enrollment by using their health coverage to obtain health care.
42. An alternative approach, with less state fiscal exposure, would use rigorous methods to obtain informed consent to enrollment, cognizant of the obligation to file later tax returns and the consequent risk of tax obligations to repay APTCs that turn out to be excessive. For example, outbound, proactive phone calls could verify the consumer's understanding. A state taking this approach could actively monitor new hires databases for people default-enrolled in zero-net-premium plans. When someone begins a new job, a state could send the person a notice reminding him or her of the need to update income records to make sure he or she does not incur a later tax liability.
43. As discussed above, prior-year income at Medicaid levels establishes a very high likelihood of current income at such levels.
44. Health status can establish Medicaid eligibility for someone who would otherwise qualify for APTCs — for example, based on pregnancy or status as a person with disabilities. One approach to this issue is for the exchange to provide notice to APTCs beneficiaries that they might be able to qualify for lower-cost coverage by seeking Medicaid eligibility based on such health conditions. That approach seeks to enroll people in health coverage without delay, avoid asking questions on tax returns that could prove problematic for tax preparers and their clients, and still let people learn about and apply for the maximum possible level of aid.

In terms of citizenship and immigration status, one state policy that would require federal cooperation involves verifying citizenship. Tax return data, including Social Security number, name, and date of birth, can enable verification of uninsured family members' citizenship based on the Social Security Administration's citizenship database and state-level databases with citizenship information. In such cases, the family member should be found eligible based on citizenship. That would require a federal finding that Affordable Care Act §1413(c)(3)'s mandate to maximize data-based application procedures creates an exception to the Personal Responsibility and Work Opportunity Act's ordinary requirements for paperwork completion. If citizenship cannot be confirmed through data matches under the approach suggested here, an uninsured tax filer and his or her family members will need to go through the standard process through which people establish citizenship or satisfactory immigration status as part of applying for Medicaid or APTCs.
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BIG IDEAS

★ 2023 ★

INTERNATIONAL ARTICLES

Introduction

Amy Goldman, GHR Foundation

Extensive research supports what parents and a majority of the care community have long believed: children have the best opportunity to thrive in safe, nourishing, and loving family environments. GHR Foundation is committed to ensuring that systems overall are oriented toward the preservation and strengthening of families. GHR partners with governments, nonprofits, civil society, the private sector, and local communities to seed and catalyze innovation, build up local community solutions and support mechanisms, facilitate capacity building, and advance research and learning to realize a shared vision of a world in which the entire care sector places the child's holistic well-being at the heart and, in the process, reduces recourse to institutional care.

Children and youth represent a large percentage of the world's population and constitute a majority in many countries. Today's is the largest generation of children and youth in human history, as one quarter of the world's population is under 14 years old and children and youth ages 10 to 24 make up an estimated 1.8 billion.¹ Yet governments and funder organizations around the world often do not treat this critical population as a top priority in policy, programming, and funding.

The COVID-19 pandemic, conflict, and climate change continue to have a disproportionate impact on children and youth, making it harder than ever for them to thrive and reach their full potential. In 2019, one billion children worldwide suffered at least one severe deprivation of life's necessities² — that is, they were without access to water, housing, nutrition, sanitation, or education. And COVID threatens to roll back decades of progress in addressing the well-being of children and youth globally.

It's estimated that more than 10 million children have lost a parent or caregiver to COVID³ and that 100 million more children⁴ have fallen into poverty, and these concerning numbers are expected to increase. Additionally, the consequences of armed conflicts and climate displacement are creating a mental health and violence crisis for children and young people everywhere.

We must act now to combat the impact of these global crises and prioritize and invest in the education, care, health, and safety of children and youth. That requires us all to work together across disciplines and interest sectors to promote an approach that focuses on the whole lifespan of children from early childhood through adolescence and youth.

Recognizing how sectors often work in siloes and the need for a multisectoral approach, GHR Foundation partnered with Oak Foundation and Wellspring Philanthropic Fund to create the Children's Policy and Funding Initiative — a pooled-donor approach that helps tackle, in a holistic manner, the variety of issues children and youth face. Contributions from our three foundations are collected into a single fund to support organizations with different priorities, strengths, and perspectives. It is critical that we not only push for a multisectoral approach within the advocacy community but also begin breaking down the siloes within funder organizations.

The Children's Policy and Funding Initiative cultivates intersectoral collaboration and strengthens efforts for a joint advocacy agenda across the children's sector. Grantees pursue a multisectoral approach based on evidence that progress and setbacks in any one sector have an impact on progress and setbacks in other sectors and that such setbacks exacerbate risks and exposure to severe harm for children and youth. The sum of the grantees' complementary strengths creates a collective force for advocacy that is stronger than their individual actions. Grantees are working to transform the U.S. government's lens to one that prioritizes young people globally. In so doing, the initiative will improve and increase policies, programming, and funding that address the myriad needs of the world's children and youth and will contribute to better outcomes for other important global priorities.

As donors, we understand the great value of promoting an approach that prioritizes children and youth holistically, both to enable a child-centered approach and augment actions on specific topics. We also applaud the policymakers who are taking leadership roles to address children and youth globally and who understand that investments in children and youth internationally are crucial for achieving their goals with respect to climate change, violence prevention, mental health, education, peace, and other global priorities.

We know that children's exposure to trauma, violence, sexual abuse, insecurity, isolation, loss of care, and disrupted education has long-term effects on their physical, psychological, and social well-being. This threatens to undermine the fabric of society and affects the future for all of us.

Urgent action is needed. We see young people around the world offering solutions, leading advocacy efforts, and mobilizing for change. Governments around the world must prioritize creating a robust approach to tackle these issues and to create opportunities for young people to meaningfully engage in decision-making processes so that policies, programming, and funding are relevant to their needs and impactful.

At GHR Foundation, we are committed to supporting these efforts, and we appeal to the funder community to look beyond their sector-specific priorities and join the call for a comprehensive and holistic approach to meeting the myriad needs of children and youth.

We also want to thank First Focus on Children for creating this publication, and we are indebted to the authors of *Big Ideas* for inspiring us all to think boldly as it will take audacious action to make a significant impact on the lives of children and youth globally.



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“How Courageous We Had to Be”

A Migrant Youth-led Photovoice Participatory Research Project

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Ron Gutierrez is the clinical director at Legal Services for Children (LSC).

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I. Introduction

The number of children who are migrants has increased more than 50%, from around 24 million during the period of 1990–2000 to 36 million in 2020.¹ Youth migrants generally have very different experiences than those of adult migrants, including their reasons for migrating, their experiences during their migration journeys, and their recommendations for other youth migrants.² Although the United Nations High Commissioner for Refugees (UNHCR) states that it is vital to place refugees at the center of the decision-making processes concerning their experiences, few opportunities exist for refugees to make recommendations for other refugees.³ As a result, research and policy concerning international youth migration rarely centers young refugee voices,⁴ often focusing on the challenges and struggles of youth migration rather than meaningfully engaging youth to draw upon their assets and lived experiences to develop solutions.

One organization working to engage youth refugees in advocacy is Family for Every Child,⁵ a member-led alliance of local and national civil society organizations that supports children around the world. As part of this alliance, the Children on the Move Working Group seeks to center young refugee voices in its work. In 2018, it began developing a two-phase research project that embraces the lived experiences of unaccompanied youth migrants and works toward enabling safer migration, improving policy and services for youth migrants, and improving the health and well-being of future young migrants and their families. In 2019, the working group began participatory action research with children on the move from Mexico and Central America, and it has now shifted to child-led advocacy for policy and transformative change. This article has been co-written by participants in the participatory research project, including both youth and participatory research facilitators.

II. The Children on the Move Photovoice Project

To explore the experiences of youth migrants and to shift toward advocacy, the Children on the Move Working Group sought a research methodology that was both participatory and action-oriented. Participatory action research (PAR) is different from most kinds of research because both researchers and the community work together to understand a situation and take an assets-based approach to change it for the better. Different levels of community involvement are possible and often include research design, data collection and/or analysis, and the determination of actions to be taken based on results.

PAR focuses on empowerment of the community where the research is happening, with the goal of improving and understanding the world by changing it.⁶ PAR can take many forms, such as participatory surveys, digital storytelling, participatory mapping, or a participatory photography method called photovoice. For this project, the Children on the Move Working Group chose to work with photovoice, due to the positive experiences of the member group Legal Services for Children's (LSC's) previous engagement with photovoice, as well as photovoice's strength as a PAR method when working with youth⁷ and with migrants.⁸

Photovoice was first developed by public health practitioners Caroline Wang and Mary Ann Burris in the 1990s and combines ideas from feminist thought, critical pedagogy traditions, and participatory photography.⁹ Photovoice is unique in that it asks individuals to take photographs in response to research questions and then facilitates a group dialogue around these photographs. Photovoice involves three main steps:

1. Individuals are asked to take photographs in response to research questions based on their concerns as well as their strengths
2. Skilled photovoice facilitators foster critical group dialogue about the photographs
3. The images, captions, and titles generated by the co-researchers are presented to those who have the power to effect change

The critical group dialogue in photovoice is generally structured to be facilitated with questions that probe concerns and strengths, with attention to the narrative power of the photographs. The original facilitation structure developed as part of the photovoice method is called the SHOWeD format, with the following guide for questions to be asked both aloud and in writing:¹⁰

S: What do you **See**? (What's the first thing you notice about this picture?)

H: What's **Happening**? (What story do you imagine this picture is telling?)

O: How does this relate to **Our** lives? (How does it make you feel, or what does it make you think about?)

W: **Why** does this situation, (concern, or strength) exist?

D: What can we **Do** about it?

This PAR project was conducted following the general photovoice methodology set forth by Caroline Wang and Mary Ann Burris¹¹ with adaptations from the photovoice toolkit by Rutgers International¹² and the participatory assessment toolkit by the UNHCR.¹³ The project ran between October 2020 and April 2022, with participants consisting of nine newly arrived, unaccompanied youth from Central America and Mexico who were all receiving legal service support from Legal Services for Children (LSC),¹⁴ a nonprofit organization in San Francisco, California that was part of this research project. Lawyers and social workers at LSC invited their clients to participate in this study as co-researchers, if eligible, and five completed the first round while four completed the second. Because the primary language of the youth was Spanish, both groups were conducted in Spanish.

Originally the intent had been for three member organizations from Family for Every Child's Children on the Move Committee to host a photovoice group: one in San Francisco, California (LSC), one in Guatemala City, Guatemala (National Association Against Child Abuse, CONACMI),¹⁵ and one in Puebla, Mexico (JUCONI).¹⁶ But with the onset of the global COVID pandemic, the planned, in-person photovoice groups had to be moved online due to public health safety concerns and laws about nonessential gatherings. Additionally, because the member organizations in Guatemala and Mexico were unable to host remote groups, the groups were consolidated from three to two. Both were hosted in California and facilitated by staff from the United States for the first group and Guatemala and Mexico for the second group, along with support from youth who had previously participated in photovoice groups with LSC. The facilitators were trained by staff from LSC as well as PAR consultants from Three Mountains consulting group. Technical assistance was provided by PAR consultants from Three Mountains and staff from Family for Every Child.

For our Children on the Move photovoice project, four research questions were developed by member groups who serve unaccompanied migrant youth in Guatemala, Mexico, and the United States:

- **Question 1: Why do you think children migrate?**
- **Question 2: What are the risks of migrating to the United States?**
- **Question 3: What helped you during the journey?**
- **Question 4: What changes are necessary for safer movement for youth migrants?**

Based on the number of research questions and the need for an introductory session and final photography exhibit, each project consisted of six weekly meetings of one and a half hours each.

III. The Photovoice Project Findings

The findings in this paper are divided into two major sections, beginning with the photo and caption responses. This section gives an overview of the co-researchers' responses to each of the questions in both photo and written forms. The second section covers the main themes that arose from both groups and gives a detailed description of each of the three main themes that co-researchers distilled from analyzing the captions, writings, group dialogues, and photos from both groups.

Photo and Caption Responses to Research Questions

In response to the research questions, youth co-researchers took photos, wrote captions, and discussed the questions together with the goal of achieving critical consciousness about youth migration and the advocacy needed to make it safer, with improved policy, health, and well-being for youth migrants and their families.

Q1: Why do you think children migrate?

With the first question, *"Why do you think children migrate?"*, participants shared photos and wrote captions that can be described as representing the following reasons:

- Migration for better opportunities
- Migration to escape crime/violence
- Migration for education
- Migration to reunify with family
- Migration due to lack of government support

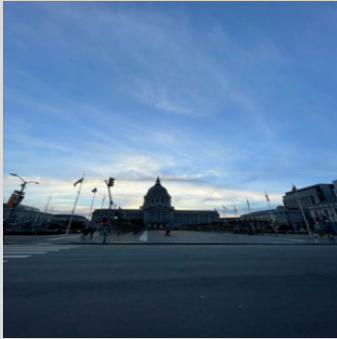
These reasons are summed up well in the photo and caption by R (*Figure 3.1*), who described the dreams that kids have in their home countries that can't be realized, forcing them to migrate to the United States to pursue better opportunities.



Many kids dream about reaching their goals, but unfortunately they don't have the opportunities to do so. Most of the time their dreams are destroyed, they have to work at an early age, quit school in order to have something to eat every day, they give up a lot to have something to eat. In Central America unfortunately there are not so many resources, unlike in this country.

Figure 3.1. Un Nuevo Amanecer, R

The reasons for migration from the two photovoice groups are consistent with earlier qualitative research with Central American migrant youth. A 2017 study that analyzed Central American migrant youth responses to questions about their migration experiences found that the motivations of economics, security, and education were all interconnected.¹⁷ Research has also shown that youth migration has been tied to their parents' migration patterns, and reunification is also a major factor for youth migration,¹⁸ as seen in Figure 3.2 by K.



I felt that something was missing, like joy, or support. I came in search of being better and being with my mom. I also didn't feel that I had someone there for me in my country. I came to the United States because I just wanted to be reunited with my mom.

Figure 3.2. Untitled, K

Q2: What are the risks of migrating to the United States?

Participants took photos in response to the second question, "What are the risks of migrating to the United States?", and the facilitators fostered dialogue among the groups to contextualize the meaning of the photos. The second question brought forth a plethora of responses from both groups, with overlapping risks between participants and groups. The photo and caption from I (Figure 3.3) give a good example of the combination of risks described by many of the participants.



Migrants can be victims of organized crime, or be kidnapped on the way, or die in the desert, or when they are trying to cross the river.

Figure 3.3. Untardecer, I

When the photos, writing, and discussions were analyzed from both groups, a list of risks emerged, ranging from physical risks to emotional risks:

- Getting lost
- Getting left behind
- Separation from family or traveling group
- Separation from family in home country
- Separation from community in home country
- Heat
- Dehydration
- Physical exhaustion
- Hunger
- Sleep deprivation
- Psychological exhaustion
- Physical injury
- Drowning
- Trauma
- Crime/violence during journey
- Death

Many of these risks have been written about in other reports, especially those concerning physical injury, crime and violence during the journey, and trauma.¹⁹ The risks that are less reported — getting lost, getting left behind, and getting separated from one's family or traveling group — are those that seem to be more prevalent for unaccompanied migrant youth versus migrant adults, especially taking into consideration the increased vulnerability of youth and their lack of adult protection. Additionally, almost all youth in both groups included "separation from family and community in home country" as risks for migration.

Along with the risks of getting lost or separated, both groups focused on the dangers of heat and extreme temperatures on the journey. Youth discussed the "strong intensity of the sun" and included photos that evoked the dangers of heat. With the shift in U.S. Border Patrol policy to "prevention through deterrence" — funneling migrants away from well-established urban crossing areas toward remote areas of deserts and mountains — studies have shown that migrants have been more exposed to extreme elements and suffer higher rates of heat-related exposure.²⁰ Other studies have shown that extreme heat has been the leading cause of death for migrants crossing the U.S. border,^{21,22} and that extreme heat and dehydration have more of an impact on youth migrants than on adults.²³ Recent research that integrated future climate predictions into models projected an increase in severe dehydration and death for migrants crossing into the United States by way of its Southern border by up to 34.1% over the next 30 years.²⁴

Finally, both groups had a strong focus on the importance of listening to the lived experiences of the dangers of the journey for migrant youth. These experiences in the voices of migrant youth are explored in more depth with photos, captions, and quotations with the themes "Uncertainty and Safety" and "Separation from Family and Home."

Q3: What helped you during the journey?

With the question, "*What helped you during the journey?*", youth co-researchers presented a wide range of photos and captions. Some youth were very literal in their responses and took photos that represented things that could help during the journey, such as improved security and oversight of guards at migrant youth detention centers (Figure 3.4).



They should at least change the security in the youth detention centers and at least pay a little more attention to the oversight of the bosses, because there are some guards who are bad, others who are good.

Figure 3.4. Untitled, E

Others took photos and discussed things that weren't necessarily captured with photos but that arose in critical group dialogue as photos were being shared and as the participants reflected on their own journeys and those of other youth to come.

Q4: What changes are necessary for safer movement for youth migrants?

The final question, "*What changes are necessary for safer movement for youth migrants?*", elicited responses similar to those to Q3. The help that youth co-researchers could see was necessary during the journey was the same as the changes necessary for safer movement for youth migrants. Using these similar answers, the photos, captions, and dialogues from both Q3 and Q4 were analyzed in order to come up with a list of changes recommended from both groups:

- Communicate risks and benefits of migration to youth before they migrate
- Protect youths with the help of adults during their migration journey
- Designate safe resting places during migration
- Provide access to food and water during migration
- Maintain access to health care during migration
- Refrain from separating families during migration
- Establish government support for youth migrants
- Supply travel visas for youth migrants
- Ensure easier and safer modes of transportation for youth migrants

One response to Q4 — a youth, A, presented a photo of two people communicating with one another (Figure 3.5) — demonstrates the importance of youth knowing the circumstances they could face during the journey.



People need to be in communication with someone while migrating to the United States. Youth need to know what they are facing.

Figure 3.5. Cuento Conmigo, A

The essential changes and support needed during the journey that the youth co-researchers discussed are well-documented as being important for migrant health and safety: support for migrants before, during, and after their journeys for physical, emotional, and social needs.²⁵ Additionally, research with migrant youth in Central America found that youth have expressed the need for expanded benefits and protections, including enhanced security along known migration routes and assistance with family reunification.²⁶

Themes

The analysis of captions, group dialogues, writing, and photos brought forth a number of themes surrounding safer youth migration and improvements to the health and well-being of future young migrants and their families. These themes were distilled into three main categories: "Separation from Family and Home," "Uncertainty and Safety," and "Hope and Resilience." Descriptions of the themes and the recommendations for action that arose from them are below.

Separation from Family and Home

The major theme that arose for youth co-researchers was separation. It emerged from responses to the research questions through photos, written narratives, and group discussions in both projects. Co-researchers described separation in the context of the homes and families they left, the dangers of their journeys, their detention experiences, and their lives in the United States.

Co-researchers discussed the sadness of having to leave their home countries, families, and friends to journey to the United States, often with the knowledge that they may never return. Many youth migrants discussed the pain of their last nights with their families and communities:

"When I left for the United States...I tried to spend the best evening with my loved ones because I knew if I crossed to this side, I could never go back..."

Youth shared stories of wanting to reunify with their mothers but knowing that would mean separating from the family who had raised them after their parents left to work in the United States.

"I remember the day I left it was very hard. My heart was broken because I had to say goodbye to my grandfather. He was like a dad to me because I grew up with him and he told me: 'go because

you have to be by your mother's side and your mom is your mom. You have to go.' He told me: 'this is the last time you will see me alive, you won't see me anymore because when you get back here I will not be here.' He passed away a little while ago and it was very hard for me. When I see this photo I feel sad because it is true...there are two choices and one is to decide to separate."

"It's very hard and what was giving me the courage to continue and not give up was my mom. I only had a few memories with her and my dream was to be with her, by the warmth of my mom that I had missed so much, that was my goal in the United States, I did it for my mom. However, I was leaving a piece of my heart in Honduras because my family is there. My grandma was like my mom, but she supported me because she also had memories of my mom. I remember when I crossed the river, it was pretty bad. I was very wet, holding onto someone and they say you have to run, and I could barely run but I had to...and it was very hard for me because I just wanted to be with my mom, I only crossed for my mom."

Another example of separation occurred in discussions of the fear of separation during migration and the risks of making this journey as a child. Youth exchanged stories of running away from immigration officials, crossing rivers, deserts, and jungles, and the crossing of the border into the United States. They described being placed in detention centers and moved many times, often for many months without being able to see the family who was waiting for them until they were released. In the first photovoice group, one youth shared a photo of a lone shoe next to railroad tracks (Figure 3.6).



I used that picture because of the railroad that leads to an unknown destination and the shoe showing that something was left behind.

Figure 3.6. *La Vida a Cambio de un Sueño*, R

This photo led to a discussion, during which other youth shared their own stories of being separated during their journeys, such as being separated from the group with which they were traveling:

"I am from Guatemala, and when we were almost at the border with the United States, we saw immigration services from Mexico, and they tried to get us so everyone started running towards the trains. I was with other people and they tried to help me, but I got lost, the only option I had left was to take the train. I didn't know if the others were on the train or not. When I went to the border with Guatemala I saw other people that were also lost. And we stayed there in Mexico for about a month."

"When I was coming here, when I was crossing the border, I had crossed a piece of it and suddenly immigration arrived by helicopter, four patrols and everyone started running to different places and I was very young so I started running too but I didn't know where, I was basically following the gentleman in front of me, but I was very young so one of the officers got me around 4 am they took me to a detention center."

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This same fear of separation was echoed in the second group, when one youth shared with the photovoice group a photo of the wilderness (Figure 3.7) and reflected on the fear they experienced while being separated from the caravan during their journey while walking through the jungle of Central America to reach the United States:



Although I traveled mostly in a group of 15 or 20 people, sometimes I would be left alone for parts, I had to walk alone, including being in the jungle alone, sleeping at night alone, surrounded by animals and all of that. So I say, thank you God. Now I see that photo and I see myself here, I see where I am and I say 'Celestial Father, help that person who is crossing right where I crossed, help them as well. Show them your mercy. May they have a blessing.'

Figure 3.7. Untitled, B

Many youth migrants commented on the strength they found in their faith or their commitment to hope, and the photos shared, narratives written, and comments made during the discussions often touched on the importance of having something larger than the journey itself to believe in.

"Something that's very important I think is to have faith or hope that you will get to the destination safe and sound and see your family or the person that is waiting for you."

"I didn't care about being mistreated, if I had to be locked up, I always had my sister in mind. My sister gave me strength to continue, because I hadn't seen her in a long time, since I was 3, maybe 4 years old. She deserved an explanation about what happened to me, and that was something that always gave me strength to reach my destination."

Finally, youth spoke strongly about not separating children from their families or their parents either during the journey or upon arrival in the United States. In the first group, youth reflected on a photo shared of a famous mural in San Francisco that depicts an immigrant separating from his family (Figure 3.8).



Many families often go through pain to find a better future and the most painful thing is family separation. In my opinion, in order to have safer migration, we must not separate families and should leave children with their parents. We must protect families, not separate them.

Figure 3.8. Un Dolor Mas, F
(mural artist J. Berger, San Francisco, 2006)

This pain of separating families was echoed by youth in both groups, as youth shared stories of being separated themselves or witnessing separations.

"When I was coming on my journey to the U.S. I had to see a lot of ugly things, in the train, in the jungle, walking — many ugly things. Mothers crying, kids crying. So much suffering, where mothers were separated from their kids. They took the kids to shelters."

"In order to make that journey safer, we have to avoid separating parents from their children so we don't traumatize children, and then we will avoid a lot of emotional problems from happening."

"To feel safe during that journey, during migration, we shouldn't separate families and we have to avoid separating parents from their children... Even if we are surrounded by a lot of security cameras, the thing that makes you feel safe, or at least feel not alone, is having your parents or any other close family member with you."

Uncertainty and Safety during the Migration Journey and after Arrival in the United States

The second major theme that arose from the groups was centered around uncertainty and safety during the migration journey and after arrival in the United States. Youth in both groups came to the United States in myriad ways: in large or small groups, by caravan, with a coyote (smuggler), via freight train, by foot, by bus, through the jungle, through the desert, and swimming across the river that makes up the border between Mexico and the United States. Although youth came in different ways, all had stories about the dangers of the journey and the risks faced along the way. Uncertainty about future safety loomed large in the photos, narratives, and discussions.

"I think it's something very risky to say I am coming to follow a dream or because I am chasing after a better economy, or being more stable."

"During the journey, you go to different places, you go down roads you don't know, you see cliffs and you think... if this car falls, or loses a tire, you finish your days here. Who knows if one day your family will have information about you or not."

"I felt that from the moment I left my country, going across Mexico, I never felt safe, I always felt insecure, I didn't even know if I would make it to this country."

"I remember when I was coming here... we were scared because we didn't know what was going to happen. It is true, during that journey you don't know what's gonna happen to you, it was very scary. Sometimes you find bad people, sometimes good ones."

And beyond the uncertainty, a common thread around risks to safety ran through both groups, with youth recounting first-hand their experiences of the journey to the United States and the dangers they faced not only while crossing into the United States but also once they arrived. In the critical group dialogue, photos served as gateways for discussion on topics that are typically difficult for many young migrants to discuss. Throughout the photovoice sessions, support was regularly exchanged between co-researchers when particularly challenging experiences were shared, such as praising the bravery they exhibited while crossing the border to the United States through the desert and river:

"Oh I want to say something, that you're very brave for crossing that way, because I think that people who cross the river coming from the desert are very brave. If I had done it I would be crying or I don't know, I couldn't do it, so it's very brave to be honest."

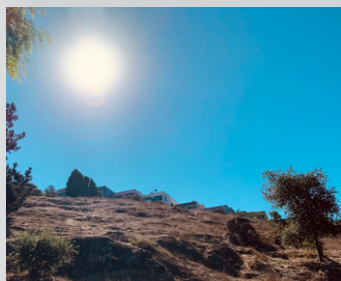
Youth also discussed how they guarded their safety, with one youth noting that they carried a machete on the journey (Figure 3.9).



When I left for my journey to the U.S., I was not able to get a passport, none of that. So what was left for me: I had to grab a machete, my luggage and a cross and travel through the jungle with a strong mind...This is a photo of my machete. The machete is as much as a weapon to survive and a weapon to defend yourself.

Figure 3.9. Machete, B

Many youth migrants also shared photos that evoked memories of risks or dangerous places from their journeys, with many of them touching upon the unrelenting heat of the desert and the dangerous roads they had to travel (Figures 3.10, 3.11).



I took this picture because the place looked similar to the roads that migrants travel. Many people have lost their lives for crossing such dangerous roads under the strong intensity of the sun.

Figure 3.10. Un Reflejo de la Realidad, F



The corner in this photo represents for me the place where our group went when we were coming from the desert. We found a place like that where we could get some rest, spend the night because we were all very tired, we couldn't walk anymore. But we found some pieces of dead bodies. We don't know if they were from people who never made it to the other side...The only thing we could do was bury them and leave them there.

Figure 3.11. La Inmigración, E

Beyond the journey, youth also shared their challenges with safety and uncertainty once they arrived in the United States. Most spent time in detention centers and expressed gratitude if their stays were only for a number of weeks rather than months.

"For me I was only [in detention] a month and a week — a lot of people had been there for more than 2 months, but it depends on every case. I didn't stay long in there. After a month and one week they took me to my brother's — it was my destination."

"I was in the first shelter for a while before they took me to a different place, to another program in Oregon, then they sent me to a different one. I spent probably around nine months in those shelters before finally at the end I was with my mom."

In one photo (Figure 3.12), a youth expressed outrage at the treatment of children once they arrive in the United States.



When you enter this country, the government has young people and children just lying on the ground. They don't put them in places where they can be taken care of or where they can get better treatment. There are some who are sick and they hardly give them any medicine. I think they should help young people who don't have the necessary resources.

Figure 3.12. Una Mejor Sociedad, E

Once youth were out of detention and experienced a current of hope, they still felt uncertain and frustrated with their situations as youth migrants in the United States.

"I was very scared the first days in the United States, I didn't even want to go to school, I would be in class and I would leave at noon because I was scared."

"We arrived in this country. Leaving family behind. A home behind. And we are so hopeful but sometimes they end up giving us nothing, like in my case. I have been here for 5 years, and they have not even given me a work permit, or anything else."

Some youth in both groups discussed their challenges with mental health, both from the trauma of the journey and the depression once they arrived in the United States (Figure 3.13).



The tree represents a person, a child who faces many barriers to migrate here. Migrating here causes pain, and in some cases, depression, and this photo for me makes me feel sad.

Figure 3.13. Sentimientos Encontrados, A

"We need to prioritize mental health, because kids suffer after they experience traumatic events on the migration journey."

Hope and Resilience

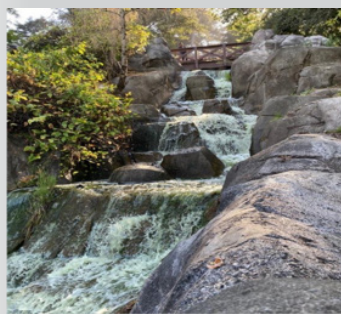
Although youth in both groups delved deeply into the challenges of separation and safety, the third theme focused on hope and resilience. Across all co-researchers, the photos, narratives, and discussions were often ones of extraordinary perseverance and hope in the face of extreme difficulties. One young migrant shared a photo of her graduation diploma (Figure 3.14), titled "An American Dream." This photo sparked congratulations and praise from her fellow co-researchers, who recognized the resilience it took her to reach this achievement. Her caption discusses the pride and joy at her graduation that were echoed in the photovoice discussion.



The picture that I'm sharing is my high school diploma where I graduated from. Just seeing it makes me feel proud of myself because I worked so hard to get it, even if it's just a piece of paper. It was my sacrifice, I spent nights up, I would cry because I couldn't understand the homework. I was stressed out because my English wasn't good enough, but in the end I got it. That diploma is proof of all the sacrifices I made for my family and it brings me pride and joy.

Figure 3.14. *Un Sueño Americano*, F

Other youth shared photos and captions that revealed their hard work towards goals that they are still working toward, day by day (Figure 3.15).



This picture for me represents that I can reach my dreams as an immigrant here, that I don't understand English that much, I can't master it, but I am learning little by little.

Figure 3.15. *El Agua*, I

Resilience arose as a strong thread throughout both groups. The American Psychological Association defines resilience as "the process and outcome of successfully adapting to difficult or challenging life experiences, especially through mental, emotional, and behavioral flexibility and adjustment to external and internal demands."²⁷ This definition is present in the narratives from youth in both groups:

"It's like a fight, like...to reach your goals you go step by step until you make it to the top. You have to take risks, sometimes dangerous risks, sometimes it's painful, but if you do it firmly, you can reach those goals, even if they are dangerous."

"In our countries we don't have enough resources to study, the economy in our countries is bad and here, in the United States, well...here we can reach our goals and the things we wanted in life."

"We all come at first with that thought of being deported. We have to keep going so we can find peace and calm. For me that's the light you see. People go through pain and somehow it changes our lives, we go through trauma."

"I liked the discussion because it helped me remember all those risks that one had to go through, how courageous we had to be, risking everything to come here."

"One of the things I have gained is strength. I went through this difficult journey...I know it hurt and it was difficult, but it was worth it."

IV. Recommendations for U.S. Policy for Children on the Move

The method of photovoice is not just a needs assessment or a method for evaluating stories or data. Its critical centerpiece is a call for action, and its roots are found in Paolo Freire's critical pedagogy. The dialogue among the youth co-researchers centered around photos elevated an individual's experience to a shared experience that could be located "within larger social, political, and historical structures."²⁸ The culmination and purpose of each photovoice project and its photo exhibit will hopefully lead to change. Youth co-researchers in both groups discussed the goal of moving beyond the first phase of this photovoice research project to the second phase of advocacy.

The first step of moving toward advocacy was to compile a list of shared recommendations from both groups for safer migration and the improvement of policy and services for youth migrants, as well as of the health and well-being of future young migrants and their families based on the co-researchers' lived experiences as youth who had migrated to the United States:

Before Youth Migration

- Ensure youth considering migration are familiar with the risks of migration
- Ensure safe transport for children migrating alone
- Provide visas or other documents to allow children to migrate safely across countries

During Youth Migration

- Stop family separation
- Provide food and water to youth migrants during their journeys
- Provide access to medical care to youth migrants during their journey
- Provide a safe place to sleep for youth migrants during their journey
- Provide clothes to youth migrants
- Provide safety monitoring for youth migrants during their journey
- Provide signs and information for youth migrants and people who interact with migrants

Youth Migrants in Detention in the United States

- Stop family separation
- Educate immigration officers about the rights of child and adult migrants
- Ensure safer, more comfortable conditions for youth migrants in detention
- Provide referral for support services (legal, social, medical, etc.) to youth migrants
- Increase case transition time once in the United States (detention to shelter to reunification with family)
- Ensure better training for detention guards
- Provide more oversight of detention conditions and guards

Youth Migrants in the United States: Integration

- Provide opportunities for youth empowerment
- Ensure better communication between the U.S. government and Central American youth migrants
- Create more peer support opportunities for youth migrants in the United States
- Offer more school support for migrant youth
- Ensure nondiscrimination at schools
- Follow up with migrant youth students even after graduation
- Offer more opportunities to create youth attachment to adults
- Offer employment development programs for migrant youth

Ethics

It is important to note that ethical precautions were included as part of this project. Because this research was conducted with vulnerable youth, the member organizations sought institutional review board (IRB) approval with their public health partner, the University of California, San Francisco. Co-researchers completed consent forms, and their control over the project and ability to withdraw consent at any time was discussed. At the beginning of every session, co-researchers were encouraged to share only what they felt comfortable with and were ensured support by the facilitators and youth facilitators. Co-researchers were given control over how images and writing would be presented, including presentations, reports, and websites. Co-researchers were also informed by the facilitators that no photographs identifying individuals would be published without consent from the photographer and the individual in the picture.²⁹ The group consisted of young people with different immigration statuses, so discussions about confidentiality were especially important for the co-researchers to feel safe during the photovoice research project process. Therefore, all co-researchers were given complete anonymity with their work, using only their first initials, not their names. Within the findings section of this report, photos and captions are associated with the first initial of the co-researchers, but quotations from group discussions are anonymized.

V. Conclusion

Although these photovoice groups faced numerous challenges, including being launched as the COVID pandemic swept the world, they were able to make the pivots necessary to move forward, connect with one another, and advocate for change. The online format was incredibly helpful during the first group's meetings, since San Francisco was primarily locked down while the group was taking place. For the second group's sessions, school had returned in person, and groups were gathering again when the online sessions began, so attendance to an online group was challenging. However, the online format enabled facilitators from Guatemala and Mexico to guide the photovoice sessions for youth in California. They were able to discuss migration with youth who had completed their journey, rather than youth who were just contemplating migration.

We were all impressed by the ability of the photovoice method to elevate the lived experiences of co-researchers who had migrated to the United States as youth. The photos helped center responses to the research questions and explore both the challenges and the assets of migration. Two co-researchers from the first photovoice group went on to be youth facilitators in the second photovoice group, and many co-researchers are working on the next phase of this project: advocating for safer migration, improved policy and services for youth migrants, and improvements for the health and well-being of future young migrants and their families.

This photovoice project contains many lessons for the U.S. government on how to include children in the design, data collection, and analysis of migration research. First, based on the numerous findings that both echoed previous research and uncovered new areas to explore, co-researchers recommend using a PAR method to involve youth when conducting research on youth migration issues. Second, the focus on photography and the power of photos and captions from youth to spur critical dialogue on such a difficult topic make the photovoice method one that is recommended for youth migration research. Third, the centerpiece of action steps that are a part of the photovoice method makes this type of research stand out. This participatory research helped create a foundation for youth migrants to advocate for U.S. policy development on youth migration, ranging from writing articles, to meeting with those with the power to effect change, to holding photovoice project exhibits. In the words of one youth co-researcher: *"I believe that this photovoice project creates hope because we talked about what we suffered to come to this place and things that we can help change for the future youth who cross the border every day."*

"How Courageous We Had to Be": A Migrant Youth-led Photovoice Participatory Research Project

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Investing in Learners Every Step of the Way

Financing Education in Emergencies

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When Esther Ngemba fled war and persecution in Congo at just 5 years old, her educational future was uncertain.¹ She and her family initially sought refuge for a few years in Kampala, Uganda, to find support for her brother, who is partially blind, but eventually officially resettled in the United States. Today, Esther is a human rights advocate, entrepreneur, and college student in Cleveland, Ohio. As a student with lived experience in emergency, refugee, and resettlement settings throughout her studies and an advocate for refugees and displaced students in Ohio, Esther has experienced first-hand the barriers and challenges to educating children and youth displaced by humanitarian crises.

When the young activist first started her advocacy, she was shocked to learn that the U.S. humanitarian aid package allocates minimal funding to education. Esther believes that it is important to prioritize such funding so that refugees can receive quality, inclusive education at their first stop, so that they are not burdened with additional work to catch up on their learning loss. At the international level, Esther says this begins with more targeted humanitarian aid specifically for education in emergencies. Additionally, for host countries such as the United States, Esther stresses the need for investment in resources that help first-generation students readjust to learning after a disruptive trauma to their mental health. That means meeting students where they are by providing teachers, psychosocial supports, and peer mentors who speak their mother tongue language and are trained in trauma-informed and culturally responsive teaching.

Esther's story embodies the United States' two-sided responsibility for investing in education in emergencies in both learners' countries of origin and our own schools here at home. The *Education in Emergencies Big Idea to Invest in Learners Every Step of the Way* paper addresses the urgent need for a swift and adequate response to provide quality, inclusive, accessible education for the hundreds of millions of students experiencing crises in their countries and seeking refuge away from home. By examining the existing policy and funding frameworks in two international case studies, Uganda and Bangladesh, we provide targeted education in emergencies and crises recommendations for the U.S. government to incorporate into and prioritize across its humanitarian responses to protracted crises. We conclude with an overview of the United States' obligation to educate first-generation students arriving at its borders and living within its communities, including key recommendations that can properly address their unique needs — building a safer, more inclusive world with quality, inclusive education for all children and youth, from the global to the local.

Setting the Stage: Education in Emergencies

The unprecedented frequency and magnitude of humanitarian emergencies threatens children's and youth's basic right to universal, quality, inclusive education. Disasters and protracted emergencies — which are often accompanied by destruction of school infrastructure, displacement, violence against children and youth, and heightened poverty levels — result in severe disruptions to students' educational journeys. Globally, numbers of children and youth affected by disaster or conflict are alarming:

- **One in three** school-aged children and youth between the ages of 5 and 17 lives in a country affected by conflict or disaster.² In total, that amounts to **222 million** students around the world.³
- An estimated 128 million primary- and secondary-school-age children and youth are out of school due to conflict or crisis.⁴
- Approximately 36.5 million students are displaced — including 13.7 million refugee and asylum-seeking children and youth and more than 22.8 million children and youth are internally displaced as a result of conflict or violence.⁵

Education plays a key role not only in the immediate reconstruction of countries experiencing a conflict or disaster but also as a tool for mitigating and preventing future disasters. Education is well known to provide benefits to students who have experienced the trauma of humanitarian and protracted crises, serving as a safe space where students receive crucial psychosocial support services and gain the necessary skills to rebuild their countries. The United States has been a top donor of education within humanitarian assistance, for example investing \$52 million to humanitarian assistance for education in 2019.⁶ However, as a proportion of overall U.S. humanitarian assistance, funding allocated to education amounted to only 0.6%,⁷ indicating a critical opportunity for the United States to display renewed leadership and commitment to education in emergencies.

Recommendations for the U.S. Government

All Levels: International, National, State, and Local

- **End violence** against children and youth, including school-related, gender-based violence, and ensure that psychosocial-emotional support is provided in schools and communities.
- **Improve coordination** across agencies currently implementing education programs in emergencies and protracted crises, with consistent mechanisms for reporting of results.⁸
- **Increase funding** for education in conflict and crisis settings and develop a consistent method to account for funding of education programs across all agencies.⁹
- Ensure an **effective transition** from humanitarian response programming to long-term education development.¹⁰

International

- **Champion investments for education in emergency and crisis settings by making an intended pledge of at least \$158 million over four years** in U.S. funding toward a \$1.5 billion fundraising goal during the Education Cannot Wait High-Level Financing Conference to be held February 16-17, 2023, in Geneva so that **Education Cannot Wait (ECW)**, the global fund for education in emergencies and protracted crises, can provide education for 20 million children and youth in conflict- and crisis-affected countries from 2023-2026.¹¹ This vital U.S. contribution would include:
 - \$18 million from Fiscal Year (FY) 2022 funds that have already been appropriated and remain after the U.S. government committed \$7 million to ECW previously in September 2022.
 - \$35 million (from FY23 funds; preliminarily approved by Congress)
 - \$105 million (minimum with at least \$35 million/year from FY24, FY25, and FY26 funds)
 - *Total: \$158 million*
- Ensure **strong U.S. leadership and engagement with the global community** on addressing these challenges, including increased U.S. financial commitments to ECW, the Global Partnership for Education, and bilateral education in emergencies and crises funding and across the humanitarian-development continuum.¹²
- **Support all levels of access to education in emergency and crisis settings**, from early childhood development to pre-primary, foundational learning, primary, secondary, and post-secondary education and for traditionally marginalized groups including girls, children and youth with disabilities, and minority groups.
- **Formally incorporate and fund education in emergencies and crises in the plans, programs, policies, and strategies** at all levels of the U.S. Agency for International Development (USAID), the U.S. Department of State's Bureau of Population, Refugees, and Migration, and all branches of the U.S. government operating in emergency and humanitarian settings.¹³ Integrate education in all U.S. Government humanitarian response efforts — both bilateral and multilateral — and continue to promote coordination across all sectors and branches of the U.S. Government.

National

- Invest in, and incentivize, the creation of teacher training programs focused on **cultural respect and understanding to respond to the social-emotional and mental health needs of first-generation students**.
- Provide adequate **bilingual education resources for multilingual learners that prioritize instruction in students' first languages**.
- Establish and develop laws, policies, funded programs, and curricula for early childhood learners, regardless of their immigration status, that aim at the **holistic development of a child's social, emotional, cognitive, and physical needs** in order to build a solid foundation for lifelong learning and well-being.¹⁴

Existing Funding and Policy Frameworks

Some existing policy and funding frameworks at the international, regional, and local levels aim to center education within humanitarian response. In 2015, Gordon Brown, the United Nations Special Envoy for Global Education, called for the establishment of a global fund dedicated to education in emergencies at the World Economic Forum in Davos. A year later, ECW, the UN global fund for education in emergencies and protracted crises, was established at the 2016 World Humanitarian Summit.

The *New York Declaration for Refugees and Migrants*,¹⁵ adopted unanimously by all 193 UN member states at the 2016 High-Level Summit for Refugees and Migrants, set out the key components of the Comprehensive Refugee Response Framework (CRRF).¹⁶ The CRRF included four key elements, two of which can be specifically applied to education for displaced communities: (1) support for immediate and ongoing needs (such as protection, health, and education) and (2) assistance to national and local host institutions and communities.¹⁷ The adoption of the CRRF should be considered a key milestone in the protection and advancement of the rights of refugees — including the right to education — especially given that 47 states “committed to legal or policy changes to enhance refugees’ access to education” at the Leaders’ Summit the next day.

Whereas some states have worked collaboratively to address the inclusion of refugees in national education systems, others have undermined refugee students’ access to education. The following case studies illustrate two countries, Uganda and Bangladesh, that have taken different approaches to supporting education for learners affected by conflict and crisis. Given that Uganda and Bangladesh are among the largest refugee-hosting countries in Africa and South Asia, examining their refugee education policies provides a useful comparative analysis of education in emergency settings.

Case Studies

Uganda’s Education Response Plan for Refugees and Host Communities

Uganda hosts the largest number of refugees in Africa; therefore, examining Uganda’s refugee education response policies is useful as a case study for other countries facing similar challenges. Between 2016 and 2017, Uganda primarily received refugees from South Sudan, the Democratic Republic of the Congo, and Burundi. Of the 1.4 million refugees in Uganda in 2018 at the time the Ministry of Education and Sports developed the multiyear Education Response Plan (ERP) for Refugees and Host Communities, just over one million refugees were from South Sudan.¹⁸ In 2018, only 43% of the more than 616,000 school-age refugee children and youth in Uganda were enrolled in a formal education system. In response to the unprecedented strain on public education, Uganda developed the ERP to ensure a coordinated service delivery in education. Since refugees in Uganda primarily lived in some of “the least developed districts in the country,” the risk of straining existing public school infrastructure was especially high.¹⁹ The ERP, aligned with the CRRF, aimed to shift Uganda’s efforts from an emergency humanitarian response toward a more sustainable and durable solution. The ERP aligns with the Ministry of Education and Sports’ wider education goals outlined in the broader Education Sector Plan.

As one of the UN High Commissioner for Refugees' (UNHCR's) pilot countries for both the Global Compact for Refugees and the CRRF, Uganda developed the ERP at a time when it was well positioned to bridge its humanitarian and development programming — as the ERP notes, Uganda was in need of “predictable and sustainable financing for this emergency and protracted crisis.”²⁰ The Ministry of Education and Sports states in the ERP that its response to emergencies is “hampered by humanitarian funding patterns (normally 12 months or less, and funding received amounting to less than 40% of identified needs).”²¹ Whereas the UNHCR-allotted budget for humanitarian activities in the country peaked at \$551.1 million in 2017 at the height of refugee arrivals, it amounted to \$343.4 million in 2022. Additionally, education alone represents 14% of the total UNHCR budget in Uganda, the second-highest-funded outcome after “self-reliance, economic inclusion, and livelihoods.” That figure surpasses the 10% of humanitarian funding toward education that is often referred to as the minimum estimate needed to ensure access to quality, inclusive, free education by the global education community.²²

Uganda's efforts to bridge the humanitarian-development divide are laudable, but there is room for improvement. We introduced Esther Ngemba at the beginning of this chapter. As a young refugee from Congo, Esther and her family fled to Uganda due to persecution by rebel groups. Esther and her family settled in Kampala, primarily because her brother, who is blind in one eye, needed special health care that was not available in a smaller town or a refugee camp. In emergency settings, people with disabilities are at an increased risk of abuse, exploitation, and deprivation due to discrimination, stigma, and a lack accessible resources in humanitarian aid programming. Access to disability-inclusive humanitarian aid, including education, continues to be a challenge in Uganda. Limited data on the number of refugee children and youth with disabilities in Uganda's refugee settlements prevent lifesaving services, such as health and education, from reaching those often left furthest behind.²³ Humanitarian aid packages and programs, including education, must prioritize disability inclusion at all levels to ensure that every student achieves the right to quality, inclusive education.

Bangladesh's Education Response to the Rohingya Refugee Crisis

In 2017, the Burmese military attacked the Rohingya Muslim minority that resided primarily in Rakhine State, causing more than 700,000 Rohingyas to flee to Bangladesh.²⁴ Although the government of Bangladesh initially welcomed Rohingya refugees fleeing Myanmar, it has refused Rohingya refugee children and youth their fundamental right to access public education services. The government justifies this decision based on a lack of Bangladeshi citizenship, which the Bangladeshi government does not offer to Rohingya refugees as it does not recognize their legal refugee status. According to an article written by a volunteer refugee teacher in the Kutupalong refugee camp in Cox's Bazar, the government of Bangladesh has made it illegal for Rohingya refugee students to access formal education outside of the refugee camp setting in Kutupalong.²⁵ In 2019, the government of Bangladesh began systematically expelling Rohingya students from secondary schools near the refugee camps in Cox's Bazar, according to reporting by Human Rights Watch.²⁶ Rohingya refugee students cannot sit for the Bangladeshi national exams and do not receive any accreditation that they have received primary or secondary schooling, which excludes them from applying to universities.

As of 2022, Bangladesh's UNHCR budget was \$285.1 million, of which 73% was dedicated to assisting refugees “realize their rights in a safe environment.”²⁷ A more detailed breakdown of the budget reveals that the amount allotted to education amounts to only 5% of the total humanitarian

aid budget.²⁸ Considering the global call to allocate a minimum of 10% of humanitarian budgets to education, Bangladesh is hardly halfway there. While the government of Bangladesh may consider this to be a short-term humanitarian situation, Rohingya Muslims continue to suffer persecution in Myanmar and refugees cannot safely return to their homes.

Recommendations

Whereas contributions from the United States to ECW to date are indicative of the U.S. government's willingness to adequately fund education in emergencies, ECW estimates that a total \$1.5 billion is still needed from all donors — including **at least \$158 million over four years from the U.S. government** — to fund education for the 20 million children and youth affected by crisis and conflict worldwide, including in Bangladesh, Uganda, and all contexts affected by emergencies and protracted crises.²⁹ As a major contributor to ECW, the United States needs to **display strong leadership, make new commitments, and engage with the global community** on addressing these challenges, especially in the lead-up to ECW's Education in Emergencies High-Level Financing Conference on February 16-17, 2023 — such commitment will be crucial to meeting funding targets and reaching all children and youth.

In addition, education should be **formally incorporated into the plans and strategies** of key U.S. agencies involved in managing and implementing education in emergency programming, such as the State Department's Bureau of Population, Refugees, and Migration and the U.S. Agency for International Development. **Improved coordination across agencies and consistent mechanisms for reporting results** will ensure that education and humanitarian funding is appropriately reaching intended populations. Additionally, given education's key role in the humanitarian-development nexus, the U.S. must prioritize ensuring an **effective transition that includes quality, inclusive education and early childhood development for children and youth** is present during all stages of the transition from humanitarian response programming to vital support during protracted crises and long-term education development.

The U.S. Response to Educate First-Generation Students

To assess the United States' foreign aid for education in emergencies without a critical analysis of our domestic responsibility to provide quality, accessible, and inclusive education to students arriving at our own borders would be an affront to the hundreds of thousands³⁰ of minors seeking refuge in the United States each year. Investments in our education systems to meet the needs of students fleeing crises are investments in the overall health and security of our economy and society. In a time when we face rising fears of an imminent global recession,³¹ policymakers must set dehumanizing, anti-immigrant rhetoric aside and invest in the entrepreneurial potential and resilience of children and youth globally and in the United States. As Esther Ngemba pointed out, when governments educate displaced populations and refugees and equip them with the right tools and services, those students will create solutions to solve the refugee crisis because they have experienced it first-hand. "This is crucial for host countries, because [governments] should want people in their country who are well educated so they can positively impact the economy," she said. In the United States, migrants account for 15% of the population, but they represent 25% of entrepreneurs.³² By forming new businesses built on their educational attainment, migrants create new jobs for all; small firms create about 1.5 million jobs every year.³³

Setting the Stage: A Challenging Educational Journey for Children and Youth

Children and youth affected by crises arrive in the United States and are quickly categorized according to their legal status. Unaccompanied children and youth, unaccompanied refugee minors, asylum seekers, migrant children and youth, undocumented children and youth, and children of undocumented parents are just a few of the identifying labels given to youth in critical need of social supports and education.³⁴ Not all children and youth are treated equally based on their legal designation.^{35,36} Esther, for example, was accompanied by her family and applied for and received asylum status as a refugee. However, for many children and youth fleeing crises, the process of being accepted into U.S. society, let alone schools, is particularly difficult and socially stigmatizing without legal documentation and holistic support. For the purposes of this paper, we refer to youth seeking refuge in the United States as “first-generation students,” and we reference legal definitions for federal documentation of population data.³⁷

Currently, about 2.1 million undocumented youth under the age of 24 reside in the United States.³⁸ More than half of undocumented students have come from Central and South America,³⁹ and many seeking refuge from the often overlapping risk factors of violence, natural disaster, poverty, and corruption.⁴⁰ Based on recent United States Census data, the Migration Policy Institute estimates at least 83,000 U.S.-residing undocumented children ages 3 to 17 are not enrolled in school.⁴¹ This stark reality contradicts long-established federal judicial precedent, including those established in *Plyler v. Doe* (1982)⁴² and *Reno v. Flores* (1993).⁴³ Regardless of their guardians’ actual or perceived national origin, citizenship, or immigration status, *Plyler* guarantees students’ equal access to public elementary and secondary education. Regarding unaccompanied minors in the custody of Immigration Services, *Reno* ensures that they receive “educational services appropriate to the minor’s level of development, and communication skills in a structured classroom setting.”

Although federal policies offer some protections, there is little oversight, and practice at the state level often varies. Local education agencies may impose illegal administrative burdens or eligibility requirements such as proof of residency that can deter families from registering their children in school.⁴⁴ Even if a district is found to be breaking federal law, for first-generation students and their families navigating the legal system, the path to justice is convoluted and time-consuming. In 2020, school closures and remote learning during the COVID-19 pandemic posed significant challenges to immigrant students whose families faced language barriers and an unknown school system. Although schools are one of the few spaces where migrant students are guaranteed public services such as social work check-ins, language instruction, speech therapy, and reading support, online learning was either ill adapted to such needs or unavailable.⁴⁵ Many students face significant emotional trauma from their journey to the United States, on top of financial stress and homelessness. Constant mobility and extreme poverty, in the aftermath of the trauma of migrating from a country in crisis, are significant underlying causes of school failure and dropout for first-generation students.^{46,47}

Scaling Up Existing Funding and Programming

Beyond legal protections, a few federal programs are in place that support migrant children's holistic needs. The Migrant Education Program (MEP) was established in the 1960s as a part of the Great Society Initiative and was later incorporated into Title I of the Elementary and Secondary Education Act, and then into the Every Student Succeeds Act as a supplemental grant made available to migrant students who move often with migratory work cycles, with or without a guardian.⁴⁸ These funds are in addition to Title I provisions to schools with high populations of students from low-income backgrounds, meaning they are intended to supplement, not supplant, other federal funds. The MEP addresses experiences and challenges particular to migrant children and children of immigrants — among them, school readiness, parental involvement, health education, and transportation. For children of farmworkers that often migrate for seasonal work, the MEP is intended to address gaps in attendance, language barriers, and lack of school peer bonds.⁴⁹ Despite those aims, a recent study of implementation at the state level found that MEP state directors often faced time and capacity constraints in addition to bureaucratic barriers, stigmas, and prejudice against migrant students, as well as a lack of sufficient funding.⁵⁰ The study found that directors spent most of their time finding out-of-school children to recruit to the MEP, which is a lengthy and costly process that detracts from students actually benefiting from the program.⁵¹

For children and youth identified as “refugees,” the federal Refugee School Impact Program provides grant funding to states specifically to offer social and educational services according to the needs of new arrivals in communities and schools. Children and youth who are considered “Unaccompanied Refugee Minors (URM)” are identified by the State Department while they are living in crisis overseas or when they have recently arrived in the United States. Such children and youth are eligible for resettlement in the United States but have no guardian available to provide long-term care. URM receive social support such as mental health services and educational support including educational training vouchers, English language training, career/college counseling, and training.⁵² Compared to the number of undocumented and migrant children, the URM program is relatively small, with about 13,000 minors included since it began in 1980.⁵³ Currently, about 1,800 children and youth are in Office of Refugee Resettlement (ORR) care.⁵⁴

Recommendations

While there are federal, state, and local programs in place in the United States to support incoming learners, investments and holistic supports still need to be targeted to meet such students' unique needs. Studies indicate that school finance litigation and policies that focus solely on expenditure and revenue patterns are not effective in improving equitable outcomes.^{55,56} A frequently cited study titled “Straw into Gold, Revenues into Results: Spinning Out the Implications of the Improved School Finance” justifies that the relationship between money and school resources is more complex than a simple input-output model. Resources must be activated by an additional catalyzing variable.⁵⁷ The study's authors explain that school resources require active participation from school communities, including families and a range of school staff and education support professionals including teachers and school administrators. In the case of children and youth fleeing conflict, community involvement is especially necessary to address the circumstances of their unique socio-emotional, health, language, protection, and support needs. Therefore, each of our recommendations goes beyond funding increases alone and addresses specific target areas.

We recommend investing in the following three critical improvements to help children and youth in the United States with lived experiences in emergency and crisis settings fully realize their rights to inclusive, quality, accessible education:

- Teacher training for cultural respect and understanding
- Adequate resources for multilingual learners
- Early childhood education

Teacher Training for Cultural Respect and Understanding

Schools are not just spaces for learning math and reading; they are social hubs where students spend the majority of their days surrounded by their peers and under the supervision of adults outside of their families. For first-generation students, learning spaces serve to socialize students — that is, they serve as a place to make lasting relationships and to familiarize children with a new culture. However, as Esther noted, schools often are unprepared to address the mental health and cultural needs of learners who have fled crises and violence. She explained that refugee students can learn the same curriculum as other students, but educators need to be equipped with an understanding of their background and the life transitions they face in and outside the classroom. One form of teacher training is known as Culturally Relevant Pedagogy, a method developed by Gloria Ladson-Billings.⁵⁸ This form of training goes beyond traditional content knowledge credentials and requires continuous self-assessment to deconstruct educators' preexisting perceptions of their students. This allows educators to examine themselves and expand their socio-emotional growth to better support and meet their students' socio-emotional and cross-cultural needs.⁵⁹ Many teacher preparation programs operate at the state or local level; therefore, we encourage the federal government to incentivize creation of culturally responsive educator training in partnership with teachers' unions at the national, state, and local levels, and the continued support of successful programs.

Adequate Resources for Multilingual Learners

Title III of the Every Student Succeeds Act stipulates funding for “language instruction for English learners and immigrant students” and takes an English-first approach to prioritizing funding for multilingual learners. In addition to calls for an adjusted funding formula to meet the needs of an influx of new learners each year, six meta-analyses involving dozens of studies provide evidence that instruction in a student's mother tongue language (whatever language that may be) can improve performance in English.⁶⁰ A Stanford University⁶¹ study found that high school students who were enrolled in bilingual programs since elementary school were more likely to be deemed proficient in English compared with similar students who had been enrolled in all-English programs. Expanding the provision of Title III funds to hire and train more linguistically diverse educators will support a growing population of multilingual learners.⁶²

Early Childhood Education

According to the Right to Education Index,⁶³ the United States falls short in providing early childhood education for the most vulnerable students. Significant research has shown the importance of investing in inclusive early childhood education and development (ECED), yet many children and youth, especially first-generation students in the United States, lack access to universal, quality, and inclusive learning environments before kindergarten. Early care and education programs

are important safe spaces for first-generation students as they are federally protected “sensitive locations”⁶⁴ from which immigration officials are generally prohibited. Therefore, it is imperative that we act now to enact policies that support the investment necessary to make high-quality early learning programs a reality for all families, regardless of their immigration status. We recommend establishing laws, policies, and curricula that aim at the holistic development of a child’s social, emotional, cognitive, and physical needs in order to build a solid foundation for lifelong learning and well-being. That will necessitate several targeted actions to ensure access to quality, inclusive early ECED programs and services, such as the following:

- Support the Child Care for Working Families Act and similar legislation
- Increase federal support for access to ECED services for all families regardless of immigration status
- Create laws and implement policies that ensure direct delivery of ECED services
- Incentivize and support states in moving toward universal pre-primary programming, including education, in ways that support socioeconomic, racial, and linguistic diversity
- Make programs affordable by subsidizing or paying full tuition for ECED programs for children from low-income families
- Encourage local government and community participation in the development of early childhood policies through the formation of localized planning groups and the development of local plans as a criterion for state funding
- Improve early educator compensation, and provide pre-service and in-service training targeting the holistic development of the child
- Provide national data on early childhood development to help track progress over time

Conclusion

The growing scale and frequency of emergencies and crises have a direct impact on the ability of children and youth around the world to exercise their right to quality, inclusive education. Esther Ngemba’s story is a powerful reminder of the United States’ double-sided responsibility to prioritize education in humanitarian aid abroad and at the same time adequately support resettled refugee, migrant, and unaccompanied students as they embark on their educational journeys in the United States.

An examination of existing funding and policy frameworks and their application in Uganda and Bangladesh demonstrates that although progress is being made, more must be done to ensure the delivery of equitable learning opportunities for the millions of students displaced by conflict and crisis. At the global level, the United States must increase funding for education in emergencies and improve coordination among the various implementing agencies and partners on the ground, including through consistent reporting mechanisms. The United States must also fulfill its own obligation to support first-generation learners, including through culturally responsive teacher education programs, adequate bilingual education resources for multilingual learners, and setting a high value on the education of conflict-affected students. Only by applying these principles can we ensure that students everywhere achieve their full potential.

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